INDIVIDUAL AND FAMILY PLAN
HEALTH CARE COVERAGE APPLICATION /ENROLLMENT/ CHANGE FORM
SUTTER HEALTH PLUS

Language Assistance
If you have questions about completing this application (in English or another language), please contact Sutter Health Plus (SHP) Member Services at 1-855-315-5800 (TTY: 1-855-830-3500), Monday through Friday from 8:00 a.m. – 7:00 p.m. Pacific Time. If needed, we will provide translation services and other language assistance services to you free of charge. If you are working with a broker, you may also call him or her for assistance. A broker who helped you read and complete this application must sign the application (see Section 8).

This form is for Individual and Family Plan enrollment. You may also use this form to update your address or phone number.

Availability of Evidence of Coverage and Disclosure Form
This application is part of the Individual and Family Plan Membership Agreement and Evidence of Coverage and Disclosure Form. By signing this form, you are accepting the terms, conditions, and provisions contained in this form and the Individual and Family Plan Membership Agreement and Evidence of Coverage and Disclosure Form. You have the right to read the Individual and Family Plan Membership Agreement and Evidence of Coverage and Disclosure Form before applying for coverage and/or enrolling in Sutter Health Plus. To obtain a copy, please contact your broker or you may contact Sutter Health Plus Member Services Department at 1-855-315-5800 (TTY: 1-855-830-3500).

Important Note: The Affordable Care Act (ACA) requires SHP to collect the Social Security numbers (SSN) for all enrolled family members. SHP is required to provide IRS Form 1095-B to the IRS with a copy to you. Form 1095-B includes information you will need to report on your income tax return showing that you and your covered family members had qualifying health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment. SHP will not use or share your SSN other than as required by law. ***Please be sure to include all SSNs where requested!***

Please keep a copy of this form for your files. **Please be sure to return all pages of this form including the last page as it contains your signature which is necessary to process these changes.** Missing information may delay processing.

Your first month premium must accompany this form (for new policy holders).

Mail your completed form to:
Sutter Health Plus
2480 Natomas Park Dr., Ste. 150
Sacramento, CA 95833

Fax or email changes and plan renewals to:
Fax: 1-916-736-5090
E-mail: SHPIFP@sutterhealth.org

Section A: Enrollment Purpose

Is the Applicant an existing or former Sutter Health Plus member? If Yes, please include your Subscriber ID here: _____	☐ Yes ☐ No

Enrollment Period:
☐ Annual Open Enrollment Period

☐ Special Enrollment Period

Qualifying Event Date: _____
(Please attach the "Qualifying Events for Special Enrollment Attestation" form)

☐ Demographic Change Only
- ☐ Name Change
- ☐ Address Change
- ☐ Phone Number Change

Enrollment or Change Type:
☐ New Enrollment
- ☐ Subscriber Only
- ☐ Subscriber and Spouse/Domestic Partner
- ☐ Subscriber and Child(ren)
- ☐ Child Only
- ☐ Family: Subscriber, Spouse/Domestic Partner, Child(ren)

☐ Existing Subscriber
- ☐ Change Plan
- ☐ Add Dependent(s)

Requested Effective Date: _____

Section A1: Plan Details and Account Information

Select the plan you would like
☐ MI01 Platinum Individual ☐ MI02 Gold Individual
☐ MI03 Silver Individual ☐ MI04 Bronze Individual

Sections to Complete

If you are applying for coverage just for:
- Yourself only (Subscriber), complete Section B (and Section D if applicable)
- Child only, complete Section B and D

If you are applying for any other coverage, complete Section B and C (and Section D if applicable)
If you are updating or changing name, address or phone, complete Section B for subscriber (and Section C for dependents if applicable)

Section B: Subscriber Information

Last Name:	First Name:	MI:

Date of Birth:	Social Security Number (required):	Subscriber ID Number (if known):	☐ Male ☐ Female

Residential Address:	City:	State:	ZIP:

Home Phone:	Mobile Phone:	Work Phone:	Email Address:

Mailing Address: (P.O. Box accepted)	City:	State:	ZIP:

Primary Spoken Language:	Previous Name (if any):

Primary Care Physician (PCP) Information – If you do not select a PCP, one will be assigned to you. You have the opportunity to change your PCP by calling Member Services at 1-855-315-5800 (TTY/TDD: 1-855-830-3500).
To find a PCP please visit: sutterhealthplus.org/providersearch

Primary Care Physician (PCP) Name: Are you a current patient? ☐ Yes ☐ No	Primary Care Physician (PCP) ID Number:

Section C: Dependent Information

Section C1: Spouse/Domestic Partner

Add: ☐ Spouse ☐ Domestic Partner	Last Name:	First Name:	MI:
Date of Birth:	Social Security (required):		☐ Male ☐ Female
Residential Address:	City:	State:	ZIP:
Mailing Address: (P.O. Box accepted)	City:	State:	ZIP:
Primary Care Physician (PCP): Is this person a current patient? ☐ Yes ☐ No	Primary Care Physician (PCP) ID:		

Section C2: Dependent One

☐ Add Child 1	Last Name:	First Name:	M.I.
Date of Birth:	Social Security (required):		☐ Male ☐ Female
Residential Address:	City:	State:	ZIP:
Mailing Address: (P.O. Box accepted)	City:	State:	ZIP:
Primary Care Physician (PCP) Name: Is this person a current patient? ☐ Yes ☐ No	Primary Care Physician (PCP) ID:		

Section C3: Dependent Two

☐ Add Child 2	Last Name:	First Name:	M.I.
Date of Birth:	Social Security (required):		☐ Male ☐ Female
Residential Address:	City:	State:	ZIP:
Mailing Address: (P.O. Box accepted)	City:	State:	ZIP:
Primary Care Physician (PCP) Name: Is this person a current patient? ☐ Yes ☐ No	Primary Care Physician (PCP) ID:		

Section C4: Dependent Three (If you need additional room, please attach a sheet of paper to the back of this form)

☐ Add Child 3	Last Name:	First Name:	M.I.
Date of Birth:	Social Security (required):		☐ Male ☐ Female
Residential Address:	City:	State:	ZIP:
Mailing Address: (P.O. Box accepted)	City:	State:	ZIP:
Primary Care Physician (PCP) Name: Is this person a current patient? ☐ Yes ☐ No	Primary Care Physician (PCP) ID:		

Section D: Financially Responsible Party for Applicant to Be Covered (for child only or court ordered coverage obligations)

If the financially responsible party is someone other than the Applicant, please complete the information below.

Last Name:	First Name:	MI:
Date of Birth:	Mobile Phone:	
Social Security Number:	Home Phone:	
☐ Male ☐ Female	Street Address: (Must be a residential street address. P.O. boxes are not accepted)	
City:	State:	Zip:
Email Address:		
Primary Spoken Language:	Subscriber ID Number (if known):	Previous Name (if any):

Section E: Other Coverage Information

Do you or any of your dependents listed above have other healthcare coverage (including Medicare or Medicaid). **If "Yes", please provide the following information.**	☐ Yes ☐ No
Type of Coverage: ☐ COBRA ☐ Group/Employer ☐ Individual ☐ Other:_____	
Will your current health care coverage be terminated upon acceptance or enrollment with Sutter Health Plus?	☐ Yes ☐ No

Primary Policy Holder Name(s) (Last, First, MI):	Policy Number:	Effective Date:
Insurance Carrier Name:	Phone:	
Insurance Carrier Address:	Individual(s) Covered Under Policy:	

Section G: First Month's Premium and Effective Date

Primary Applicant Effective Date Notification	First month's premium must accompany this form for the application to be considered complete. We will notify you of your effective date in your acceptance letter. If you have questions regarding your enrollment status, please contact your broker or Sutter Health Plus Member Services 1-855-315-5800, Monday through Friday from 8:00 a.m. – 7:00 p.m. Pacific Time.
New Dependent Effective Date Notification	If you and your dependents are enrolling together, the effective date for the primary applicant (subscriber) will also apply to all dependents. A newborn or a newly adopted child is automatically covered from the moment of birth for thirty days following birth. The child must be enrolled within 60 days after birth for membership to become effective and continue coverage beyond the first thirty days after birth. Please reference the Individual and Family Plan Membership Agreement and Evidence of Coverage and Disclosure Form for further details on enrolling a newborn or adopted child.

Section H: Agent, Broker, or Representative Information

For Applicants using an insurance agent, broker, or representative.

The broker of record may receive monetary payments from Sutter Health Plus in connection with the purchase of this coverage. Premiums are the same whether or not you use an agent, broker, or other representative.

Agent, Broker, or Representative Name:

Section G1: To be completed by your Agent, Broker, or Representative after completion of this application.

If you have assisted the Applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8I or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

I assisted the Applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the Applicant, in easy-to-understand language, the risk to the Applicant of providing inaccurate information, and the Applicant understood the explanation.

X_____

Agent, Broker, Representative Signature **Today's Date**

Last Name: Knauss	First Name: Kevin	MI:
Street address: 8712 Pendleton Drive		
City: Granite Bay	State: CA	Zip: 95746
Phone: 916-521-7216	Fax:	Email Address: kevin@insuremekevin.com
Agency Name: Kevin Knauss	License Number: 0H12644	SHP ID Number: A-00514673 C-00979260

Section H: Member Agreement – Please read the following information carefully.

AGREEMENT TO BE BOUND

I declare that I have read this application, the answers provided, and the documents enclosed. I have had an opportunity to review the Individual and Family Plan Membership Agreement and Disclosure Form and Evidence of Coverage (Agreement) and by signing this document accept all terms and rates and conditions set forth in the Agreement. I certify that the information provided with this application is true, complete, and correct to the best of my knowledge.

If this application is accepted by the health plan, then my signature will result in a binding contract with the health care coverage, terms and conditions set forth in the Individual and Family Plan Subscriber Contract, Evidence of Coverage and Disclosure Form.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Sutter Health Plus to disclose to my Sutter Health Plus broker or agent the status of my application for coverage, as well as that of any Applicant on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for coverage.

THIRD PARTY RECOVERY

I understand that by signing below I am agreeing to grant a lien on third party recoveries. For more information please refer to the section entitled Third Party Responsibility – Subrogation in the Individual and Family Plan Subscriber Contract, Evidence of Coverage and Disclosure Form.

BINDING ARBITRATION

Sutter Health Plus (SHP) handles and resolves Member disputes through grievance, appeal and Independent Medical Review processes. However, in the event that a dispute is not resolved in those processes, Sutter Health Plus uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Individual and Family Plan Subscriber Contract, Evidence of Coverage and Disclosure Form.

X_____

Applicant / Financially Responsible Party **Today's Date**