

# Small Group Plan

## 2026 Employee Enrollment/Change Form

### How to use this form:

You may use this form to enroll in coverage with Sutter Health Plan. You may also use this form to notify us of changes to existing members, such as a name, address, telephone number, or subaccount change. All changes to accounts, including effective dates and dependent status, will be made in accordance with the contractual agreement between the employer/purchaser and Sutter Health Plan.

**This form is not used to notify us of a subscriber termination.**

### How to submit your application:

For Sutter Health Plan to process your request, you must complete, sign and return this form. Missing information may delay processing.

**Employers, please email or fax the completed form to:**



EMAIL

shpserviceteam@sutterhealth.org



FAX

916-736-5426

### Important Note

The Affordable Care Act (ACA) requires Sutter Health Plan to collect the Social Security numbers (SSNs) for all enrolled members. Sutter Health Plan 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. Sutter Health Plan will not use or share your SSN other than as required by law. **Please be sure to include all SSNs where requested.**

Employer Group Name

Sutter Health Plan Account Number

Effective Date

Subaccount Name and Group Number (If applicable)

#### Enrollment – Please complete entire form.

##### Reason For Request:

Annual Open Enrollment

Newly Eligible – Reason .....

New Hire

COBRA – Effective Date .....

Cal-COBRA\* – Effective Date .....

\* Cal-COBRA enrollees will receive a separate Cal-COBRA Election Notice and Enrollment Form to complete. The notice includes important information regarding healthcare coverage options and rates.

#### Change – Complete the required information in Sections B and C, if applicable.

Member ID (For changes) .....

Plan Change\*\*

Add Dependent\*\*

Add Newborn/Newly Adopted Child\*\*

Remove Dependent\*\*\* – Effective Date .....

Name Change

Address Change

Subaccount Change

From Subaccount ID

To Subaccount ID

\*\* Date of qualifying event (If not open enrollment)

\*\*\* Please complete section C

## Section A – Benefit Plan Selection

### STANDARD PLANS

#### Section A1 – HMO Standard Plan Selection

|                             |  |  |  |
|-----------------------------|--|--|--|
| <b>Platinum</b><br>MS90 HMO | <b>Gold</b><br>SD32 HDHP HMO<br>MS93 HMO<br>MS97 HMO | <b>Silver</b><br>SD31 HDHP HMO<br>MS94 HMO | <b>Bronze</b><br>SD23 HDHP HMO<br>MS49 HMO |
|-----------------------------|--|--|--|

### PLUS PLANS

#### Section A2 – HMO Plus Plan Selection (Plus plans include embedded Infertility and Special Footwear benefits)

|                             |  |  |  |
|-----------------------------|--|--|--|
| <b>Platinum</b><br>MP90 HMO | <b>Gold</b><br>SP32 HDHP HMO<br>MP93 HMO<br>MP97 HMO | <b>Silver</b><br>SP31 HDHP HMO<br>MP94 HMO | <b>Bronze</b><br>SP23 HDHP HMO<br>MP49 HMO |
|-----------------------------|--|--|--|

#### Optional Adult Vision Benefit

If selected by your employer, you and your dependents age 19 and older will be automatically enrolled in the optional adult vision benefit plan. However, you may opt out of this coverage by checking the box below.

Please do not enroll me or my dependents in the optional adult vision benefit (if selected by my employer). I understand that I will not be able to obtain this coverage until the next applicable open enrollment or special enrollment period.

Note: Pediatric vision benefits for members up to age 19 (until the end of the month in which the member turns 19 years of age) are included in all Sutter Health Plan small group plans. Please refer to your EOC for coverage information.

## Section B – Employee Information

|                                     |                          |                                   |               |                  |
|-------------------------------------|--------------------------|-----------------------------------|---------------|------------------|
| Last Name                           |                          | First Name                        |               | MI               |
| Gender                              | Date of Birth (Required) | Social Security Number (Required) |               | Member ID Number |
| M F U <sup>1</sup>                  |                          |                                   |               |                  |
| Residential Address                 |                          | City                              | State         | ZIP              |
| Home Phone                          | Mobile Phone             | Work Phone                        | Email Address |                  |
| Mailing Address (P.O. Box accepted) |                          | Same as residential               | City          | State ZIP        |
| Previous Name (If any)              |                          | Primary Spoken Language           |               |                  |

**PCP Information** – You need to select a primary care physician (PCP) for yourself and each covered family member. If you do not select a PCP, one will be assigned. You have the opportunity to change your PCP by calling Customer Service at 855-315-5800 (TTY 855-830-3500) or on the Member Portal. To find a PCP, please visit [sutterhealthplan.org/providersearch](https://sutterhealthplan.org/providersearch).

I would like to select my PCP

I would like a PCP assigned

PCP First Name

PCP Last Name

Provider ID#

Current Patient?

P

Yes

No

<sup>1</sup>Unknown/Undeclared/Nonbinary

**Section C – Dependent Information****Section C1 – Spouse/Domestic Partner****Add to my plan****Remove from my plan**

|                                     |                          |                                   |               |     |
|-------------------------------------|--------------------------|-----------------------------------|---------------|-----|
| Spouse<br>Domestic<br>Partner       | Last Name                | First Name                        |               | MI  |
| Gender                              | Date of Birth (Required) | Social Security Number (Required) | Email Address |     |
| M   F   U <sup>1</sup>              |                          |                                   |               |     |
| Residential Address                 | City                     |                                   | State         | ZIP |
| Mailing Address (P.O. Box accepted) | Same as residential      | City                              | State         | ZIP |

|                              |                             |
|------------------------------|-----------------------------|
| I would like to select a PCP | I would like a PCP assigned |
| PCP First Name               | PCP Last Name               |
| Provider ID#                 | Current Patient?            |
| P                            | Yes   No                    |

**Section C2 – Dependent****Add to my plan****Remove from my plan**

|                                     |                          |                                   |               |
|-------------------------------------|--------------------------|-----------------------------------|---------------|
| Last Name                           | First Name               |                                   | MI            |
| Gender                              | Date of Birth (Required) | Social Security Number (Required) | Email Address |
| M   F   U <sup>1</sup>              |                          |                                   |               |
| Residential Address                 | City                     |                                   | State   ZIP   |
| Mailing Address (P.O. Box accepted) | Same as residential      | City                              | State   ZIP   |

|                              |                             |
|------------------------------|-----------------------------|
| I would like to select a PCP | I would like a PCP assigned |
| PCP First Name               | PCP Last Name               |
| Provider ID#                 | Current Patient?            |
| P                            | Yes   No                    |

<sup>1</sup> Unknown/Undeclared/Nonbinary

**Section C – Dependent Information Cont.****Section C3 – Dependent****Add to my plan****Remove from my plan**

|                                     |                          |                     |                                   |  |               |             |  |
|-------------------------------------|--------------------------|---------------------|-----------------------------------|--|---------------|-------------|--|
| Last Name                           |                          |                     | First Name                        |  |               | MI          |  |
| <div></div>                         |                          |                     | <div></div>                       |  |               | <div></div> |  |
| Gender                              | Date of Birth (Required) |                     | Social Security Number (Required) |  | Email Address |             |  |
| M   F   U <sup>1</sup>              | <div></div>              |                     | <div></div>                       |  | <div></div>   |             |  |
| Residential Address                 |                          |                     | City                              |  | State         | ZIP         |  |
| <div></div>                         |                          |                     | <div></div>                       |  | <div></div>   | <div></div> |  |
| Mailing Address (P.O. Box accepted) |                          | Same as residential | City                              |  | State         | ZIP         |  |
| <div></div>                         |                          | <div></div>         | <div></div>                       |  | <div></div>   | <div></div> |  |

**I would like to select a PCP****I would like a PCP assigned**

PCP First Name

PCP Last Name

Provider ID#

Current Patient?

P

Yes

No

**Section C4 – Dependent****Add to my plan****Remove from my plan**

|                                     |                          |                     |                                   |  |               |             |  |
|-------------------------------------|--------------------------|---------------------|-----------------------------------|--|---------------|-------------|--|
| Last Name                           |                          |                     | First Name                        |  |               | MI          |  |
| <div></div>                         |                          |                     | <div></div>                       |  |               | <div></div> |  |
| Gender                              | Date of Birth (Required) |                     | Social Security Number (Required) |  | Email Address |             |  |
| M   F   U <sup>1</sup>              | <div></div>              |                     | <div></div>                       |  | <div></div>   |             |  |
| Residential Address                 |                          |                     | City                              |  | State         | ZIP         |  |
| <div></div>                         |                          |                     | <div></div>                       |  | <div></div>   | <div></div> |  |
| Mailing Address (P.O. Box accepted) |                          | Same as residential | City                              |  | State         | ZIP         |  |
| <div></div>                         |                          | <div></div>         | <div></div>                       |  | <div></div>   | <div></div> |  |

**I would like to select a PCP****I would like a PCP assigned**

PCP First Name

PCP Last Name

Provider ID#

Current Patient?

P

Yes

No

<sup>1</sup> Unknown/Undeclared/Nonbinary

Section D – Other Coverage Information

Will you or one of your dependents have any other health plan coverage (in addition to Sutter Health Plan) after your enrollment effective date?

Yes                  No

If you check yes, Sutter Health Plan will send you a Coordination of Benefits Form to complete and return.

Section E – Agreement

You have the right to read the Group Subscriber Contract and Evidence of Coverage and Disclosure Form (EOC) before enrolling in Sutter Health Plan. To help you make an informed choice, we make available Summary of Benefits and Coverage (SBC) documents. SBCs summarize important information about our health coverage options in a standardized format so you can easily compare benefits and coverage offered by Sutter Health Plan with those of other carriers. To obtain a copy, contact your employer or call Sutter Health Plan Customer Service **855-315-5800** (TTY 855-830-3500). This enrollment form is part of the Group Subscriber Contract and EOC. You are accepting the terms, conditions, and provisions of the Group Subscriber Contract and EOC, upon completion and execution of this enrollment form.

Binding Arbitration

Sutter Health Plan 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 Plan uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plan, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plan, 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 Plan, 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 Group Subscriber Contract and EOC.

Employee Signature

Date

## Notice of Language Assistance

**IMPORTANT:** Can you read this? If not, Sutter Health Plan can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plan Customer Service at 855-315-5800 (TTY 855-830-3500). (English)

**IMPORTANTE:** ¿Puede leer esto? Si no puede, Sutter Health Plan puede proporcionarle a alguien que lo ayude a leerlo. También puede obtener este documento en su idioma. Llame al Servicio de Atención al Cliente de Sutter Health Plan al 855-315-5800 (TTY 855-830-3500). (Spanish)

**重要事項：**您能閱讀這些內容嗎？如果不能閱讀，Sutter Health Plan 可以安排人員幫助您閱讀。您還可能可以獲得以您的語言編寫的這些內容。如需免費幫助，請致電 Sutter Health Plan 客戶服務部，電話號碼：855-315-5800 (TTY 855-830-3500)。 (Chinese)

ملاحظة مهمة: هل بمقدورك قراءة هذا؟ إذا لم تكن قادرًا على ذلك، يُمكن لخطة Sutter Health Plan أن تأتي بشخص يُساعدك على قراءته. كذلك قد يكون من الممكن تزويدك بنسخة منه مكتوبة بلغتك. للحصول على مساعدة مجانية، يُرجى الاتصال بخدمة العملاء التابعة لخطة Sutter Health Plan على هاتف 855-315-5800 (أو بخط الكتابة عن بُعد 855-830-3500 [TTY]). (Arabic)

**ԿԱՐԵՎՈՐ Է:** Կարո՞ղ եք սա կարդալ: Եթե ոչ, Sutter Health Plan-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն: Դուք կկարողանաք նաև ստանալ այն գրված Ձեր լեզվով: Անվճար օգնության համար զանգահարեք Sutter Health Plan-ի Հաճախորդների սպասարկման բաժին՝ 855-315-5800 (TTY 855-830-3500) հեռախոսահամարով: (Armenian)

**សំខាន់៖** តើអ្នកអាចអានដាច់ទេ? បើអានមិនដាច់ទេ Sutter Health Plan អាចឱ្យគេជួយអ្នកអានបាន។ អ្នកក៏ប្រហែលជាអាចទទួលបានឯកសារនេះសរសេរជាភាសាបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទៅកាន់ផ្នែកសេវាអតិថិជន Sutter Health Plan តាមលេខ 855-315-5800 (TTY 855-830-3500)។ (Cambodian)

**نکته مهم:** آیا می‌توانید این مطلب را بخوانید؟ اگر نمی‌توانید، Sutter Health Plan می‌تواند از فردی کمک بگیرد تا آن را برایتان بخواند. همچنین امکان دریافت این مطالب به زبان شما وجود دارد. برای دریافت کمک به صورت رایگان، لطفاً با خدمات مشتریان Sutter Health Plan از طریق شماره تلفن 855-315-5800 (TTY 855-830-3500) تماس بگیرید. (Farsi)

**महत्वपूर्ण:** क्या आप इसे पढ़ सकते/ती हैं? यदि नहीं, तो सट्टर हेल्थ प्लान (Sutter Health Plan) इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवा सकते/ती हैं। निःशुल्क सहायता के लिए, कृपया Sutter Health Plan ग्राहक सेवा को 855-315-5800 (TTY 855-830-3500) पर कॉल करें। (Hindi)

**TSEEM CEEB:** Koj puas tuaj yeem nyeem qhov no tau? Yog tias tsis tau, Sutter Health Plan tuaj yeem kom ib tus neeg pab koj nyeem nws. Tsis tas li ntawd, tej zaum koj kuj tseem tuaj yeem tau txais qhov no sau ua koj hom lus thiab. Yog xav tau kev pab dawb, thov hu rau Sutter Health Plan Lub Chaw Pab Cuam Qhua ntawm 855-315-5800 (TTY 855-830-3500). (Hmong)

重要: こちらの文書が読めますか? 読むのが難しいときは、サッター ヘルス プランが読むのをお手伝いするスタッフを手配します。また、これを日本語で書いてもらうこともできます。無料でのサポートをご利用いただくには、電話 855-315-5800 (TTY 855-830-3500)、サッター ヘルス プラン カスタマー サービスにご連絡ください。(Japanese)

중요 사항: 이것을 읽으실 수 있습니까? 만약 읽으실 수 없는 경우, Sutter Health Plan 은 귀하가 읽으실 수 있도록 다른 사람을 시켜 도와 드릴 수 있습니다. 또한 이 내용을 자신이 사용하는 언어로 작성하도록 하실 수도 있습니다. 비용 부담 없이 도움을 받으시려면 Sutter Health Plan 고객 서비스에 전화를 하십시오. 전화: 855-315-5800 (TTY 855-830-3500). (Korean)

ສຳຄັນ: ທ່ານສາມາດອ່ານຂໍ້ຄວາມນີ້ໄດ້ບໍ່? ຖ້າບໍ່ໄດ້, Sutter Health Plan ສາມາດໃຫ້ຄົນຊ່ວຍທ່ານອ່ານຂໍ້ຄວາມນີ້. ນອກຈາກນີ້, ທ່ານຍັງອາດຈະສາມາດຂໍໃຫ້ຂຽນເປັນພາສາຂອງທ່ານໄດ້. ຫາກຕ້ອງການການຊ່ວຍເຫຼືອໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ກະລຸນາໂທຫາຝ່າຍບໍລິການລູກຄ້າຂອງ Sutter Health Plan ທີ່ເບີ 855-315-5800 (TTY 855-830-3500). (Laotian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਸੱਟਰ ਹੈਲਥ ਪਲਾਨ (Sutter Health Plan) ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਬਿਨਾਂ ਲਾਗਤ ਦੇ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਸੱਟਰ ਹੈਲਥ ਪਲਾਨ ਦੀ ਗਾਹਕ ਸੇਵਾ ਨੂੰ 855-315-5800 (TTY 855-830-3500) 'ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО. Вы можете это прочитать? Если нет, Sutter Health Plan может предоставить вам того, кто сможет помочь вам прочитать это. Вы также можете получить этот документ в письменной форме на своём языке. Для бесплатной помощи позвоните в отдел обслуживания клиентов Sutter Health Plan по телефону 855-315-5800 (TTY 855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plan ng taong makakatulong sa iyo na basahin ito. Maaari mo ring hilingin na ipasulat ito sa iyong wika. Para sa walang bayad na tulong, mangyaring tumawag sa Sutter Health Plan Customer Service sa 855-315-5800 (TTY 855-830-3500). (Tagalog)

หมายเหตุ: คุณอ่านข้อความนี้ออกหรือไม่ ถ้าหากคุณอ่านไม่ออก Sutter Health Plan สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากคุณต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาติดต่อ Sutter Health Plan Customer Service ได้ที่ 855-315-5800 (TTY 855-830-3500) (Thai)

QUAN TRỌNG: Quý vị có thể đọc thông tin này không? Nếu không, Sutter Health Plan có thể yêu cầu ai đó đọc giúp cho quý vị. Quý vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Khách Hàng của Sutter Health Plan theo số 855-315-5800 (TTY 855-830-3500). (Vietnamese)