

Small Group Plan

2026 Employer Healthcare Coverage Application

How to submit this application:

You must email or fax your signed and completed form to Sutter Health Plan. Missing information may delay processing your application.



EMAIL

shpserviceteam@sutterhealth.org



FAX

916-736-5418

To complete the application process, please make your initial premium payment online or by check. (Please select one.)

ONLINE

Pay your initial premium through the Sutter Health Plan Online Payment Center:

sutterhealthplan.org/binderpayment

If you paid online, please include the email confirmation number for faster processing.

Confirmation # _____

CHECK

Sutter Health Plan
P.O. Box 278136
Sacramento, CA 95827-8136

If paying by check, please include a copy with your application for faster processing.

Legal Company Name

DBA (Account Name)

Requested Effective Date

Section A – Benefit Plan Selection (All deductibles and out-of-pocket maximums will accrue on a calendar year basis.)

STANDARD PLANS

Section A1 – HMO Standard Plan Selection

Platinum

MS90 HMO

Gold

SD32 HDHP HMO
MS93 HMO
MS97 HMO

Silver

SD31 HDHP HMO
MS94 HMO

Bronze

SD23 HDHP HMO
MS49 HMO

PLUS PLANS

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

Platinum

MP90 HMO

Gold

SP32 HDHP HMO
MP93 HMO
MP97 HMO

Silver

SP31 HDHP HMO
MP94 HMO

Bronze

SP23 HDHP HMO
MP49 HMO

All Sutter Health Plan plans prescription drug coverage is, on average, expected to equal or exceed the standard Medicare Part D benefit value. This is considered creditable coverage. Since this coverage is creditable, Medicare-eligible individuals do not have to enroll in a Medicare prescription drug plan while they maintain this coverage. Be aware, however, that if the individual has a subsequent break in this coverage of 63 days or longer any time after they were first eligible to enroll in a Medicare prescription drug plan, the individual could be subject to a late enrollment penalty in addition to the Medicare Part D premium.

Section A3 – Optional Benefits Selection

Decline all optional benefits

Please select the plan(s) you would like:

Acupuncture and Chiropractic (ACN)

Not available for HDHPs

Acupuncture-only plan ID

Chiropractic-only plan ID

Acupuncture and
Chiropractic plan ID

Decline

Dental (Delta Dental)

Adult Dental HMO/DS01

Decline

Vision (VSP)

Plan A / VA01 12/24/24

Plan B / VA02 12/12/24

Plan C / VA03 12/12/12

Decline

Section A4 – Subaccounts (Enrollment/Billing Unit)

Please select the subaccount type, provide the physical address, and indicate if a separate invoice is needed.

Active

COBRA

Cal-COBRA*

Early Retirees

Other:

Street Address (P.O. Boxes not accepted)

City

State

ZIP

Separate Invoice (If the billing address differs)

Billing Address

City

State

ZIP

Active

COBRA

Cal-COBRA*

Early Retirees

Other:

Street Address (P.O. Boxes not accepted)

City

State

ZIP

Separate Invoice (If the billing address differs)

Billing Address

City

State

ZIP

Active

COBRA

Cal-COBRA*

Early Retirees

Other:

Street Address (P.O. Boxes not accepted)

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Separate Invoice (If the billing address differs)

Billing Address

City

State

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Active

COBRA

Cal-COBRA*

Early Retirees

Other:

Street Address (P.O. Boxes not accepted)

City

State

ZIP

Separate Invoice (If the billing address differs)

Billing Address

City

State

ZIP

*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.

Section B – Group Information

Street Address (P.O. Boxes not accepted)	City	County	State	ZIP
Federal Employer ID Number		SIC Code*		
Phone	Fax	Chief Executive Officer or Proprietor		
Workers' Compensation Carrier		Workers' Compensation Policy Number		

We affirm that we have a valid legal exemption from Workers' Compensation coverage requirements pursuant to the California Labor Code.

Are your benefits subject to ERISA regulations? Yes No

Type of Organization

Sole Proprietorship Corporation Partnership LLC Other _____

Benefits Administrator	Title
Phone	Email
Correspondence Address Same as street address above	City State ZIP
Billing Contact (If different from above)	Billing Address Same as correspondence address
Billing City	Billing State Billing ZIP
Billing Contact Email	Billing Contact Phone

Employer Contribution (A value is required for both employees and dependents. If N/A, enter "0".)

Employees _____ % of premium or \$ _____ Dependents _____ % of premium or \$ _____

Please apply: Across all plans To the lowest-cost plan

Note: Employer must contribute a minimum of 50% of eligible employee premium for the lowest-cost medical plan offered by the employer.

Employee Eligibility Minimum hours worked per week _____

* Look up your SIC Code on the Division of Corporation Finance: Standard Industry Classification (SIC) Code List at sec.gov/info/edgar/siccodes.htm.

Section B – Group Information Cont.

Total Employee Participation (Please enter a value for each line. If N/A, enter "0".)

- Full-time and full-time equivalent employees (Sole proprietors, spouses of sole proprietors, partners of partnership and the spouses of partners are not eligible employees pursuant to California Health and Safety Code section 1357.500.)
- Eligible employees in group
- Eligible employees enrolling in Sutter Health Plan
- Eligible employees enrolling in other carrier(s)
- Eligible employees waiving medical coverage from all carriers

Eligible Employees – Employees eligible for health plan benefits who live, physically work or reside within the Sutter Health Plan licensed service area.

Full-time Employee – Employee working a minimum of 30 hours per week on average.

Full-time Equivalent (FTE) Employee – A combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee.

Will Sutter Health Plan be the only carrier? Yes No

If "No":

Name of other carrier(s)

Plan(s) offered

Prior carrier

Continuation Coverage

Federal COBRA (20 or more employees for at least 50% of the previous calendar year.)

Cal-COBRA (Up to 19 employees for at least 50% of the previous calendar year.)

Federal COBRA Administrator's Contact Information

Vendor		Contact Name	
Correspondence Address		City	
State	ZIP	Phone	Email
Please mail the COBRA billing statement to:		COBRA Administrator	Group Benefits Administrator

Section C – Broker & General Agency Information

Section C1 – Broker Information

Broker Agency Name

Agency License Number and Expiration Date

Exp.

Sutter Health Plan Agency ID

A-

Broker/Agent Name

Agent License Number and Expiration Date

Exp.

Sutter Health Plan Agent ID

C-

Broker Account Manager Name

Broker Account Manager Email

Section C2 – General Agency Information

General Agency Name

General Agency Contact Name

Section D – Premium Payment Information

Section D1 – Initial Premium Payment

You can make your initial premium payment online or by check. If paying by check, it must be in the form of a corporate check payable to Sutter Health Plan and received before the group submission is considered complete. Temporary checks will not be permitted unless accompanied by a letter from your financial institution confirming your account name and address.



ONLINE

Pay your initial premium through the Sutter Health Plan Online Payment Center:

sutterhealthplan.org/binderpayment



CHECK

Sutter Health Plan
P.O. Box 278136
Sacramento, CA 95827-8136

Section D2 – Subsequent Premium Payments

You can make your subsequent premium payments online or by check.



ONLINE

After you register for a portal account, you can pay your monthly premium online through your Sutter Health Plan portal account and the Sutter Health Plan Online Payment Center.

shplan.org/employerportal



CHECK

Please make your check payable to Sutter Health Plan and include your Sutter Health Plan account name and account number with your payment.

Sutter Health Plan
P.O. Box 278136
Sacramento, CA 95827-8136

If you have questions about completing this form, please contact Sutter Health Plan Customer Service at **855-315-5800**.

This application is part of the Group Subscriber Contract, which includes the Evidence of Coverage and Disclosure Form (EOC). By signing this application form, you are accepting the terms, conditions, and provisions contained in the enrollment form as well as those in the Group Subscriber Contract and EOC. You have the right to read the Group Subscriber Contract and EOC before applying for coverage with Sutter Health Plan. To obtain a copy, contact your broker or call Sutter Health Plan Customer Service at **855-315-5800** (TTY 855-830-3500).

Mandatory Arbitration

Group, member (including any heirs or assigns) and Sutter Health Plan agree and understand that any and all disputes by and between them, 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 claims subject to ERISA, shall be determined by submission to 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. Each party, including any heirs or assigns, to this Agreement is giving up its constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and EOC.

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Employer Signature

.....

Date

.....

Print Name and Title

Note: Generally, employers cannot impose a waiting period greater than 90 days. Benefits are effective the first of the month following the waiting period. If you have questions about rules on waiting periods, please consult your legal counsel.