

Small Group Plan

2025 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 Plus Online Payment Center:

sutterhealthplus.org/binderpayment

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

Confirmation # _____

CHECK

Sutter Health Plus
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	Gold	Silver	Bronze
MS78 HMO MS90 HMO	SD22 HDHP HMO MS72 HMO MS87 HMO MS93 HMO	SD21 HDHP HMO MS94 HMO	SD13 HDHP HMO* MS39 HMO

PLUS PLANS

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

Platinum	Gold	Silver	Bronze
MP78 Plus HMO MP90 Plus HMO	SP22 Plus HDHP HMO MP72 Plus HMO MP87 Plus HMO MP93 Plus HMO	SP21 Plus HDHP HMO MP94 Plus HMO	SP13 Plus HDHP HMO* MP39 Plus HMO

* For this Benefit Year, this benefit plan does not provide eligible Medicare beneficiaries with prescription drug coverage that is expected to pay on average as much as the standard Medicare Part D coverage in accordance with Centers for Medicare and Medicaid Services. The coverage is less than the Medicare drug benefit and therefore considered "not-creditable coverage". Eligible Medicare beneficiaries who have gone more than 63 days in a row without creditable prescription drug coverage may face a Part D late-enrollment penalty. Refer to Medicare.gov for complete details.

Section A – Benefit Plan Selection Continued

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 any and all subaccounts that apply. Enter the name of any additional subaccounts if needed.

Active

COBRA

Cal-COBRA*

Early Retirees

Please list subaccounts (include address) that require a separate invoice:

.....

.....

* 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

** 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.

Benefits Administrator	Title		
Phone	Email		
Correspondence Address (P.O. Boxes accepted)	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 _____

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 _____

Section B – Group Information Cont.

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

.....

Sutter Health Plan Agency ID

A-.....

Broker/Agent Name

.....

Agent License Number and Expiration Date

.....

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 D – Premium Payment Information Cont.

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

Section E – Employer Agreement

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.

.....
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.