Agency Application

Sutter Health Plan

Please submit the following with this application:

- Legible copy of Agency's current California Life and Health License
- Signed and dated Business Associate Agreement
- Signed and dated Solicitor Firm Agreement
- W9 Form
- Proof of Errors and Omissions Insurance Coverage

Email your completed form to:
shpserviceteam@sutterhealth.org

Section A – Agency Information

Agency Name	Phone

Mailing Address	City	State	ZIP

Phone	Agency Tax ID #

Section B – Agency License Information

License Type	State of Issue	License #

Issue Date	Expiration Date	Name on License

Section C – Errors and Omissions Insurance

Name of Carrier

Expiration Date	Specific Amount (minimum $1 million)	Aggregate Amount (minimum $1 million)

Sutter Health Plan