Section A – Enrollment

Is the applicant an existing or former Sutter Health Plus member? ☐ Yes ☒ No

If Yes, please include your Member ID here .....

Enrollment Period

- ☒ **Annual Open Enrollment Period**
- ☐ **Special Enrollment Period**

  Qualifying Event Date .....

  Please complete the Attestation Form for Qualifying Events for Special Enrollment included
- ☐ **Demographic Change Only**
  - ☐ Name Change
  - ☐ Address Change
  - ☐ Phone Number Change

Enrollment or Change Type

- ☒ **New Enrollment**
- ☐ **Existing Subscriber**
  - ☐ Change Plan
  - ☐ Add Dependent(s)

Requested Effective Date 1/1/2023

Section A1 – Plan Details and Account Information

Select the plan you would like

☐ (2023) Platinum MI01 HMO* ☐ (2023) Gold MI02 HMO* ☒ (2023) Silver MI03 HMO* ☐ (2023) Bronze MI04 HMO*

Sections to Complete

If you are applying for coverage for:

- Yourself only (subscriber), complete **Section B** *and Section E if applicable*
- Child only, complete **Sections B, D and E**

If you are applying for any other coverage, complete **Sections 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 information is different from subscriber.*

You need to select a primary care physician (PCP) for yourself and each covered family member. Please include your PCP's name and provider ID in **Sections B and C**.

** This plan's prescription drug coverage is, on average, expected to equal or exceed the value of standard Medicare Part D benefit. 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 B – Subscriber Information

Last Name Kosturos | **First Name** Christine | **MI** D

Gender ☐ M ☒ F ☐ U[1] | **Date of Birth** *(Required)* 10/18/1958 | **Social Security Number** *(Required)* 566-31-3999 | **Email Address** *(Required)* ckosturos@gmail.com

Residential Address 56 W. Santa Inez Avenue | **City** San Mateo | **State** CA | **ZIP** 94402

Home Phone 650-343-8734 | **Mobile Phone** 650-218-3203 | **Work Phone** Same

Mailing Address *(P.O. Box accepted)* ☐ Same as residential | **City** | **State** | **ZIP**

Previous Name *(If any)* | **Primary Spoken Language** English

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 Member Services at 1-855-315-5800 (TTY 1-855-830-3500) or on the Member Portal. To find a PCP, please visit ***sutterhealthplus.org/providersearch***.

☒ I would like to select my PCP ☐ I would like a PCP assigned

PCP First Name | **PCP Last Name**

Provider ID# P | **Current Patient?** ☒ Yes ☐ No

Section C – Dependent Information

Section C1 – Spouse/Domestic Partner ☐ Add to my plan

☐ Spouse ☐ Domestic Partner | **Last Name** P | **First Name** | **MI**

Gender ☐ M ☐ F ☐ U[1] | **Date of Birth** *(Required)* | **Social Security Number** *(Required)* | **Email Address**

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# P | **Current Patient?** Yes No

[1]*Unknown/Undeclared/Nonbinary*

Section C – Dependent Information Continued

Section C2 – Dependent One ☐ Add to my plan

☐ Child
☐ Parent/ Stepparent

Last Name | **First Name** | **MI**

Gender
☐ M ☐ F ☐ U[1]

Date of Birth *(Required)* | **Social Security Number** *(Required)* | **Email Address**

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#
P

Current Patient?
☐ Yes ☐ No

Section C3 – Dependent Two ☐ Add to my plan

☐ Child
☐ Parent/ Stepparent

Last Name | **First Name** | **MI**

Gender
☐ M ☐ F ☐ U[1]

Date of Birth *(Required)* | **Social Security Number** *(Required)* | **Email Address**

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#
P

Current Patient?
☐ Yes ☐ No

[1]*Unknown/Undeclared/Nonbinary*

Section C – Dependent Information Continued

Section C4 – Dependent Three ☐ **Add to my plan**

☐ Child
☐ Parent/ Stepparent

Last Name | **First Name** | **MI**

Gender
☐ M ☐ F ☐ U[1]

Date of Birth *(Required)* | **Social Security Number** *(Required)* | **Email Address**

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#
P

Current Patient?
Yes No

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**

Gender
☐ M ☐ F ☐ U[1]

Date of Birth | **Social Security Number** *(Required)* | **Email Address** *(Required)*

Residential Address | **City** | **State** | **ZIP**

Home Phone | **Mobile Phone** | **Work Phone**

Mailing Address *(P.O. Box accepted)* ☐ Same as residential | **City** | **State** | **ZIP**

Previous Name *(If any)* | **Primary Spoken Language**

[1]*Unknown/Undeclared/Nonbinary*

Section E – Parent or Legal Guardian *(if the primary applicant is a child under 18)*

☐ same as financially responsible party

Last Name | **First Name** | **MI**

Gender ☐ M ☐ F ☐ U[1] | **Date of Birth** | **Social Security Number** *(Required)* | **Email Address** *(Required)*

Residential Address | **City** | **State** | **ZIP**

Home Phone | **Mobile Phone** | **Work Phone**

Mailing Address *(P.O. Box accepted)* ☐ Same as residential | **City** | **State** | **ZIP**

Previous Name *(If any)* | **Primary Spoken Language**

Section F – Premium Payment Information and Effective Date

Section F1 – First Month's Premium Payment

For your application to be considered complete, you must make your first month's premium payment, online or by check, when you apply for coverage. 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 at 1-855-315-5800, Monday through Friday from 8 a.m. to 7 p.m.

ONLINE

Pay your first month's premium through the Sutter Health Plus Online Payment center:
sutterhealthplus.org/binderpayment

CHECK

Make your check payable to Sutter Health Plus. Please use the Remittance Slip on page 9 and send your initial premium payment to:

Sutter Health Plus
P.O. Box 740143
Los Angeles, CA 90074-0143

Section F2 – Subsequent Premium Payments

To ensure we promptly process and post payments to your account, please mail premium checks to the following address:

Sutter Health Plus
P.O. Box 740143
Los Angeles, CA 90074-0143

Please include the subscriber identification number in the memo line of your check.

You also have the choice to pay your premium online once you have created your Sutter Health Plus Member Portal account. For more information, please call Sutter Health Plus Member Services at 1-855-315-5800.

Section F3 – 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 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. A newly adopted child's (including a child placed with you for adoption) membership will begin on the date when the adopting parent gains the legal right to control the child's healthcare. Please reference the *Indvidual and Family Plan Membership Agreement* and *Evidence of Coverage and Disclosure Form* (*EOC*) for more information on enrolling a newborn or adopted child.

[1]*Unknown/Undeclared/Nonbinary*

Section G – Other Coverage Information

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

☐ **Yes** ☒ **No** (If you check yes, Sutter Health Plus will send you a Coordination of Benefits Form to complete and return.)

Section H – Agent, Broker or Representative Information

For applicants using an insurance agent, broker, or representative

A three percent commission will be paid to the agent or agency on a monthly basis for which the coverage is effective and premium has been received. Premiums are the same whether or not you use an agent, broker, or other representative.

Agent, Broker, or Representative Name _____

Section H1 – 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 1389.8l 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.

Agent, Broker or Representative Signature _____ **Date** _____

Last Name | **First Name** | **MI**

Street Address

City | **County** | **State** | **ZIP**

Phone | **Fax** | **Email Address**

Agency Name | **Agent License Number** | **SHP ID Number** C-