NEW CAREGIVER BENEFIT ELECTION FORM

CAREGIVER NAME:_____ **CAREGIVER #:**_____

EMAIL ADDRESS: _____ **PHONE #:** _____

**** MUST BE SUBMITTED WITHIN 30 DAYS OF HIRE DATE! ****

FOR DETAILED BENEFIT INFORMATION, RATES AND PLAN DOCUMENTS, PLEASE VISIT WWW.SPARROWBENEFITS.ORG IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE TOTAL REWARDS HOTLINE AT 517 364-5333 OR EMAIL BENEFITS@SPARROW.ORG.

MEDICAL INSURANCE	
Please select the plan you would like to enroll in: ☐Sparrow PPO Base Plan (not available to MNA PESCH/Home Care) ☐Sparrow PPO Plus Plan ☐Sparrow HSA Plan ☐Blue Cross Blue Shield Plan (not available to MAC) ☐Health Insurance Opt Out must provide insurance plan information below: Plan name:_____, Group number:_____, Subscriber name:_____	*Please select the coverage level you would like to enroll in:* ☐Caregiver Only ☐Caregiver and Spouse ☐Caregiver and Children ☐Family Coverage
DENTAL INSURANCE	
Please select the plan you would like to enroll in: ☐Delta Dental Base Plan ☐Delta Dental Buy Up Plan ☐Delta Dental EPO Plan (not available to MNA)	*Please select the coverage level you would like to enroll in:* ☐Caregiver Only ☐Two person ☐Family
VISION INSURANCE	
Please select the plan you would like to enroll in: ☐ Base Plan ☐ Buy Up Plan	*Please select the coverage level you would like to enroll in:* ☐Caregiver Only ☐Two person ☐Family
FLEXIBLE SPENDING ACCOUNTS	**HEALTH SAVINGS ACCOUNT**
Please select the plan you would like to enroll in: ☐ Dependent Care Spending Account Annual Amount Requested: _____ Per Pay Period Amount Requested:_____ ☐ Medical Flexible Spending *(Please note not available if electing Sparrow HSA Plan)* Annual Amount Requested: _____ Per Pay Period Amount Requested:_____	*Please select the plan you would like to enroll in:* ☐ Health Savings Account (*Please note this option is only available when selecting the Sparrow HSA Plan*) Annual Amount Requested: _____ Per Pay Period Amount Requested:_____

DISABILITY INSURANCE

Please select the coverage level you would like to enroll in, for pricing please see www.SparrowBenefits.org :

☐Voluntary Short-Term Disability

☐Voluntary Long-Term Disability

☐Buy Up Long-Term Disability Coverage

☐Buy Down Long-Term Disability Coverage (MNA and UAW only)

DEPENDENT INFORMATION ***You must provide Dependent Verification documentation if electing benefits for any dependents (birth certificate, marriage license, etc.)***

First Name Middle Initial Last name	Date of Birth	Social Security Number	Relationship	Coverage Elected	
				☐MEDICAL ☐DENTAL ☐VISION	☐ADD ☐REMOVE
				☐MEDICAL ☐DENTAL ☐VISION	☐ADD ☐REMOVE
				☐MEDICAL ☐DENTAL ☐VISION	☐ADD ☐REMOVE
				☐MEDICAL ☐DENTAL ☐VISION	☐ADD ☐REMOVE

_____ _____

Caregiver Signature Date

WHEN COMPLETE PLEASE SEND TO SPARROW HUMAN RESOURCES BY MAIL, EMAIL, FAX OR DROP OFF:
SPARROW HUMAN RESOURCES
1200 E MICHIGAN AVE
STE 235
LANSING MI 48912
FAX: 517-364-5872
BENEFITS@SPARROW.ORG

*********HUMAN RESOURCES INTERNAL USE ONLY*********

Group Name	**Group Number**	**Sub Group Number**	**Class Number**	**Effective Date**

Qualifying Event Date	Qualifying Event Reason: ☒New hire ☐Status Change ☐Other:	☐Full Time ☐Part Time	☐Union ☐Non union	☐Salaried ☐Hourly