STATUS CHANGE/PERSONAL EVENT CAREGIVER BENEFIT ELECTION FORM

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

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

**** MUST BE SUBMITTED WITHIN 30 DAYS OF QUALIFYING EVENT/STATUS CHANGE ****

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) ☐ Waive/Drop Coverage ☐ 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) ☐ Waive/Drop Coverage	*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/change: ☐ Base Plan ☐ Buy Up Plan ☐ Waive/Drop Coverage	*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/change:* ☐ 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 ☐ Waive/Drop Voluntary Short-Term Disability Coverage

☐ Voluntary Long-Term Disability ☐ Waive/Drop Voluntary Long-Term Disability Coverage

☐ Buy Up Long-Term Disability Coverage ☐ Waive/Drop Buy Up Long-Term Disability Coverage

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

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