Sparrow Health HSA Enrollment Form

PLEASE PRINT LEGIBLY

Application for Medical Coverage	**Waiver of Coverage:** I decline coverage for: ☐ Employee & all dependents ☐ Spouse only ☐ Dependents only Reason: ☐ Covered under another health plan ☐ Other (specify): _____

A. Employee & Family Information

Employee's Last Name	First Name	Middle Initial	Social Security Number / /

Street Address PO Box Apt. No.	City	State	Zip

Home Phone - -	Work Phone - -	Email @	Language preference

Date of Birth / /	Gender ☐Female ☐Male	Ethnicity	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Independent Contractor? ☐ Yes ☐No	

Please list family members to be covered under this policy. Please attach additional form if needed. Write name as it should appear on ID Card. Dependent may not be eligible if other medical coverage is available to them through their employer.

	First Name M.I. Last Name	Social Security Number	Relation	Gender	Date of Birth	Medical Insurance available from his/her employer?
1		/ /		☐Female ☐Male	/ /	☐Yes ☐No
2		/ /		☐Female ☐Male	/ /	☐Yes ☐No
3		/ /		☐Female ☐Male	/ /	☐Yes ☐No
4		/ /		☐Female ☐Male	/ /	☐Yes ☐No
5		/ /		☐Female ☐Male	/ /	☐Yes ☐No

B. Coordination of Benefits – (Failure to complete this section may result in delays in enrollment or claim payments)

On the day your coverage begins, will any family members above be covered by other medical or Medicare insurance?
☐**No** ☐ **Yes If yes, please complete this section and attach a copy of the card.** Please use extra paper if more than one additional policy will be in force.

Coverage type (please attach copy of other medical insurance card): ☐ Medical Insurance ☐ Medicare	Name of Policy Holder	Policy Holder Date of Birth / /

Insurance Company Name & Phone Number	Policy Number	Policy Holder's Employer

Medicare Policy Number	Medicare Part A Effective Date	Medicare Part B Effective Date	Medicare Part D Effective Date	Medicare Part C Effective Date

Reason for Medicare: ☐End Stage Renal Disease ☐ Disability ☐ Over age 65 ☐Over age 65 and working	Please list everyone covered by other insurance:	Coverage Dates:

C. Employee Signature – this form must be signed by the employee even if waiving coverage.

ACCURACY OF INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage. **NOTICE OF ENROLLMENT RIGHTS**: I understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may be able to enroll myself and my dependents in this policy if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing towards my or my dependents' other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, I understand that if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents. However, I must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, I can contact PHP Customer Service at (517) 364-8500.

Employee Signature _____ Date Signed _____

D. For Employer Use only – must be completed in order to process

Group Name	Group Number	Sub Group Number	Class Number	Effective Date / /

Qualifying event date: / /	Qualifying event reason: ☐ Open Enrollment ☐ New Hire ☐ Return ☐ Status Change ☐ Other (Specify)	☐ Full Time ☐ Part Time	☐Union ☐ Non Union	☐ Salaried ☐ Hourly

Employer Representative Printed Name: Phone Number: - -

Employer Representative Signature **(required)**: _____ Date Signed:_____

For questions regarding this form, please e-mail – php.enrollment@phpmm.org or call the PHP Enrollment Department at (517) 364-8320