

Sparrow Health PPO Base Change Form



Employee must sign this form for anything other than a termination of employment.

A. Employee information (as it appears on ID Card)

First Name	Last Name	Social Security Number	Date of Birth
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B. Employee Changes

Change Address to: _____

Change Name from: _____ to: _____

C. Change in Coverage

Addition(s) to Medical Coverage	Qualifying Event Reason: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of other coverage <input type="checkbox"/> Other (specify): _____	Effective Date of Addition:
Termination(s) to Medical Coverage	Reason: <input type="checkbox"/> Termination <input type="checkbox"/> Death <input type="checkbox"/> Now ineligible <input type="checkbox"/> Divorce <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Other (specify): _____	Effective Date of Termination: *
Changes: <input type="checkbox"/> Change to COBRA coverage <input type="checkbox"/> Change from Class _____ to Class _____	Qualifying Event Reason: <input type="checkbox"/> Termination <input type="checkbox"/> Reduced hours <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Employee entitled to Medicare <input type="checkbox"/> Death of Covered Employee <input type="checkbox"/> Loss of "Dependent Child" Status	Effective Date of Change:

Please list family members to be added/deleted 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	Date of Birth	Gender	Relationship	Medical Insurance available from his/her employer?
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change						<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change						<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change						<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No

D. 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: <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Medicare	Name of Policy Holder	Policy Holder Date of Birth
Insurance Company Name: Phone Number:	Policy Number	Policy Holder's Employer
Medicare Policy Number	Please list everyone covered by other insurance	Coverage Dates:
Reason for Medicare: <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disability <input type="checkbox"/> Over age 65 <input type="checkbox"/> Over age 65 and working	Medicare Part B Effective Date	Medicare Part C Effective Date
		Medicare Part D Effective Date

E. Employee Signature (This form must be signed by the employee unless canceling coverage due to employee termination)

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: _____

F. For Employer Use Only (Must be completed in order to process)

Group Name	Group Number	Sub Group Number	Class Number	Effective Date
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Employer Representative Printed Name: _____

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

By checking this box, I certify that the affected individual was notified of the loss of coverage prior to the termination date.

For questions regarding this form, please e-mail benefits@sparrow.org, or call (517) 364-5333