

Sparrow Health

PPO Plus Enrollment Form



PLEASE PRINT LEGIBLY

| | |
|---|--|
| Application for Medical Coverage | Waiver of Coverage: I decline coverage for: <input type="checkbox"/> Employee & all dependents <input type="checkbox"/> Spouse only <input type="checkbox"/> Dependents only Reason: <input type="checkbox"/> Covered under another health plan <input type="checkbox"/> 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 @ | |
| Date of Birth / / | Gender <input type="checkbox"/> Female <input type="checkbox"/> Male | Ethnicity | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated |
| Independent Contractor? <input type="checkbox"/> Yes <input type="checkbox"/> 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 | | | | / / | | <input type="checkbox"/> Female <input type="checkbox"/> Male | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2 | | | | / / | | <input type="checkbox"/> Female <input type="checkbox"/> Male | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3 | | | | / / | | <input type="checkbox"/> Female <input type="checkbox"/> Male | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4 | | | | / / | | <input type="checkbox"/> Female <input type="checkbox"/> Male | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5 | | | | / / | | <input type="checkbox"/> Female <input type="checkbox"/> Male | / / | <input type="checkbox"/> Yes <input type="checkbox"/> 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): <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 | Medicare Part A Effective Date | Medicare Part B Effective Date |
| | Medicare Part D Effective Date | Medicare Part C Effective Date |
| 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 | 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: <input type="checkbox"/> New Hire <input type="checkbox"/> Return <input type="checkbox"/> Status Change <input type="checkbox"/> Other (Specify) | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time | <input type="checkbox"/> Union <input type="checkbox"/> Non Union | <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly |

Employer Representative Printed Name: _____ Phone Number: _____

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

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