Sparrow Health System

Effective date: _____

I would like to elect coverage: ☐ Base Coverage ☐ Buy Up Coverage
I would like to remove coverage: ☐ YES (Please check dependents to remove below)

Last Name	**First Name**	**Middle Initial**
Date of Birth	**Caregiver Number _____** **Social Security Number_____**	

Coverage level: ☐ **Employee Only** ☐ **Employee + 1** ☐ **Employee + Family**

Dependents covered on the plan:

Last Name	**First Name**	**Date of Birth**	**Relationship**	**Remove?**
				☐
				☐
				☐
				☐
				☐

Signature **Date**