



NEW HIRE CAREGIVER BENEFIT ELECTION FORM

CAREGIVER NAME: _____ CAREGIVER #: _____

EMAIL ADDRESS: _____ PHONE #: _____

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.

ELECTIONS MUST BE COMPLETED AND SUBMITTED TO HR WITHIN 30 DAYS OF HIRE!

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
 - Health Savings Account – Caregiver Contribution (optional – must not exceed \$5800/year or \$6800/year if over 55)); Per Pay Period Contribution Requested: _____
- Blue Cross Blue Shield Plan (not available to MAC)
- Opt Out of Health (**must complete Health Opt Out portion below to confirm coverage from outside of Sparrow)

Please select the coverage level you would like to enroll in:

- Caregiver Only
- Caregiver and Spouse
- Caregiver and Children
- Family Coverage

HEALTH INSURANCE OPT OUT ****must be completed if electing Opt Out of Health option above**** *By opting out you authorize Sparrow HR to contact the employer listed below to confirm health insurance coverage.*

Name of Health Plan: _____

Group #: _____

Contract/Member ID #: _____

Subscriber Name: _____

Employer Name: _____

Employer Address: _____

Employer Contact #: _____

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)
- No Dental Insurance

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:

- Base Plan
- Buy Up Plan
- No Vision Insurance

Please select the coverage level you would like to enroll in:

- Caregiver Only
- Two person
- Family

MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)
Please select the plan you would like to enroll in: <input type="checkbox"/> Medical Flexible Spending (Please note not available if electing Sparrow HSA Plan) Annual Amount Requested: _____	Please select the plan you would like to enroll in: <input type="checkbox"/> Dependent Care Spending Account Annual Amount Requested: _____

DISABILITY & SUPPLEMENTAL LIFE INSURANCES

DETAILED BENEFIT ELIGIBILITY INFORMATION CONTAINED WITHIN THE BENEFITS IN BRIEF (BIB) PROVIDED TO YOU BY TALENT ACQUISITION. FOR PRICING AND ENROLLMENT FORMS, PLEASE SEE WWW.SPARBOWBENEFITS.ORG OR ON THE HR INTRANET, BENEFITS PAGE UNDER BENEFIT FORMS

DEPENDENT INFORMATION *Please provide Dependent Verification documentation if electing benefits for any dependents (ex. birth certificate, marriage license, adoption/guardianship paperwork)*****

First Name	Middle Initial	Last name	Date of Birth	Social Security Number	Relationship	Coverage Elected (select all that apply)
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION

Caregiver Signature

Date

WHEN COMPLETE PLEASE SUBMIT 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 EMAIL: BENEFITS@SPARROW.ORG **MUST BE SUBMITTED WITHIN 30 DAYS OF HIRE**

*******HUMAN RESOURCES INTERNAL USE ONLY*******

Group Name	Group Number	Sub Group Number	Class Number	Effective Date
Qualifying Event Date	Qualifying Event Reason: <input checked="" type="checkbox"/> New hire <input type="checkbox"/> Status Change <input type="checkbox"/> Other:	<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