

STATUS CHANGE/PERSONAL EVENT BENEFIT ELECTION FORM

NAME: _____ TEAM MEMBER #: _____

EMAIL ADDRESS: _____ PHONE #: _____

****MUST ALSO COMPLETE BENEFIT STATUS CHANGE/PERSONAL EVENT FORM AND PROVIDE PROOF OF CHANGE****

MUST BE SUBMITTED WITHIN 30 DAYS OF CHANGE EVENT!

FOR DETAILED BENEFIT INFORMATION, RATES AND PLAN DOCUMENTS, PLEASE VISIT

WWW.SPARBOWBENEFITS.ORG IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE HR SERVICE CENTER HOTLINE AT 517 364-5333 OR EMAIL BENEFITS@UMHSPARROW.ORG.

MEDICAL INSURANCE	
<p><i>Please select the plan you would like to enroll in:</i></p> <p><input type="checkbox"/> UM Health-Sparrow PPO Base Plan (not available to MNA PESCH/Home Care RN)</p> <p><input type="checkbox"/> UM Health-Sparrow PPO Plus Plan</p> <p><input type="checkbox"/> UM Health-Sparrow HSA Plan</p> <p><input type="checkbox"/> Blue Cross Blue Shield Plan (not available to MAC)</p> <p><input type="checkbox"/> No Coverage Required (may qualify for Opt-Out Bonus)</p> <p><input type="checkbox"/> Health Insurance Opt-Out Bonus must provide insurance plan information below: Plan Name: _____, Group Number: _____, Subscriber Name: _____</p>	<p><i>Please select the coverage level you would like to enroll in:</i></p> <p><input type="checkbox"/> Team Member Only</p> <p><input type="checkbox"/> Team Member + 1 (BCBS Only)</p> <p><input type="checkbox"/> Team Member and Spouse</p> <p><input type="checkbox"/> Team Member and Child(ren)</p> <p><input type="checkbox"/> Family Coverage</p>
DENTAL INSURANCE	
<p><i>Please select the plan you would like to enroll in:</i></p> <p><input type="checkbox"/> Delta Dental Bronze (EPO) Plan (not available to MNA PESCH/Home Care RN)</p> <p><input type="checkbox"/> Delta Dental Silver (Base) Plan</p> <p><input type="checkbox"/> Delta Dental Gold (Buy Up) Plan</p> <p><input type="checkbox"/> No Coverage</p>	<p><i>Please select the coverage level you would like to enroll in:</i></p> <p><input type="checkbox"/> Team Member Only</p> <p><input type="checkbox"/> Two Person</p> <p><input type="checkbox"/> Family</p>
VISION INSURANCE	
<p><i>Please select the plan you would like to enroll in:</i></p> <p><input type="checkbox"/> VSP Bronze Plan (not available to MNA PESCH/Home Care RN)</p> <p><input type="checkbox"/> VSP Silver (Base) Plan</p> <p><input type="checkbox"/> VSP Gold (Buy Up) Plan</p> <p><input type="checkbox"/> No Coverage</p>	<p><i>Please select the coverage level you would like to enroll in:</i></p> <p><input type="checkbox"/> Team Member Only</p> <p><input type="checkbox"/> Two Person</p> <p><input type="checkbox"/> Family</p>
FLEXIBLE SPENDING ACCOUNTS	HEALTH SAVINGS ACCOUNT
<p><i>Please select the plan you would like to enroll in:</i></p> <p><input type="checkbox"/> No Dependent Care Spending Account</p> <p><input type="checkbox"/> Dependent Care Spending Account Annual Amount Requested: _____ Per Pay Period Amount Requested: _____</p> <p><input type="checkbox"/> No Medical Flexible Spending Account</p> <p><input type="checkbox"/> Medical Flexible Spending (Please note not available if electing UM Health-Sparrow HSA Plan) Annual Amount Requested: _____ Per Pay Period Amount Requested: _____</p>	<p><i>Please select the plan you would like to enroll in:</i></p> <p><input type="checkbox"/> No Team Member Contribution Account</p> <p><input type="checkbox"/> Health Savings Account (Please note this option is only available when selecting the Sparrow HSA Plan) Annual Amount Requested: _____ Per Pay Period Amount Requested: _____</p>

DISABILITY INSURANCE

Please refer to your Benefits In Brief if you have questions regarding eligibility. Please select the coverage level you would like to enroll in, for pricing please reach out to HR at benefits@umhsparrow.org

Voluntary Short-Term Disability (MNA PECSH and MNA-HC Rehab Hourly, Non-Union and UAW Hourly Part-Time Benefit Elig, SEIU and IUE Hourly, Ionia and Clinton Non-Union Full Time Hourly)

Voluntary Long-Term Disability (MNA PECSH Part-Time only)

Buy Up Long-Term Disability Coverage (Non-Union, MNA PECSH Salaried, MNA-HC Rehab Salaried, SEIU and IUE FT Hourly, UAW Full Time)

Buy Down Long-Term Disability Coverage (MNA PECSH, MNA-HC RN Full Time and UAW only)

DEPENDENT INFORMATION ***You will need to provide Dependent Verification documentation if electing benefits for any dependents (birth certificate, marriage license, etc.)***

First Name	Middle Initial	Last Name	Date of Birth	Social Security Number	Relationship	Coverage Elected	
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
						<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE

Team Member Signature

Date

WHEN COMPLETE PLEASE SEND TO SPARROW HUMAN RESOURCES BY MAIL, EMAIL, FAX OR DROP OFF:
SPARROW HUMAN RESOURCES
1400 E MICHIGAN AVE.
LANSING MI 48912
FAX: 517-364-5872
BENEFITS@UMHSPARROW.ORG

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

Group Name	Group Number	Sub-Group Number	Class Number	Effective Date
Qualifying Event Date	Qualifying Event Reason: <input type="checkbox"/> New Hire <input checked="" 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