NEW TEAM MEMBER BENEFIT ELECTION FORM

NAME: _____ **TEAM MEMBER #:** _____

EMAIL ADDRESS: _____ **PHONE #:** _____

**** MUST BE SUBMITTED WITHIN 30 DAYS OF HIRE DATE! ****

FOR DETAILED BENEFIT INFORMATION, RATES AND PLAN DOCUMENTS, PLEASE VISIT WWW.SPARROWBENEFITS.ORG IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE HR SERVICE CENTER HOTLINE AT 517 364-5333 OR EMAIL BENEFITS@UMHSPARROW.ORG.

MEDICAL INSURANCE

Please select the plan you would like to enroll in:

☐UM Health-Sparrow PPO Base Plan (not available to MNA PECSH/Home Care RN)
☐UM Health-Sparrow PPO Plus Plan
☐UM Health-Sparrow HDHP w/HSA Plan
☐Blue Cross Blue Shield Plan (not available to MAC)
☐No Coverage Required (may qualify for Opt-Out Bonus)
☐Health Insurance Opt Out Bonus - Must provide insurance plan information below:
Plan Name: _____,
Group Number: _____,
Subscriber Name: _____

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

☐Team Member Only
☐Team Member + 1 (BCBS Only)
☐Team Member and Spouse
☐Team Member and Child(ren)
☐Family Coverage

DENTAL INSURANCE

Please select the plan you would like to enroll in:

☐Delta Dental Bronze (EPO) Plan (Not available to MNA PECSH/Home Care RN)
☐Delta Dental Silver (Base) Plan
☐Delta Dental Gold (Buy Up) Plan
☐No Coverage

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

☐Team Member Only
☐Two Person
☐Family

VISION INSURANCE

Please select the plan you would like to enroll in:

☐ VSP Bronze (New) Plan (Not available to MNA PECSH/Home Care RN)
☐ VSP Silver (Base) Plan
☐ VSP Gold (Buy Up) Plan
☐No Coverage

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

☐Team Member Only
☐Two Person
☐Family

FLEXIBLE SPENDING ACCOUNTS

Please select the plan you would like to enroll in:

☐ No Dependent Care Spending Account
☐ Dependent Care Spending Account
Annual Amount Requested: _____
Per Pay Period Amount Requested:_____

☐ No Medical Flexible Spending Account
☐ Medical Flexible Spending *(Please note not available if electing Sparrow HSA Plan)*
Annual Amount Requested: _____
Per Pay Period Amount Requested:_____

HEALTH SAVINGS ACCOUNT

Please select the plan you would like to enroll in:

☐ No Team Member Contribution Account
☐ Health Savings Account (*Please note this option is only available when selecting the Sparrow HSA Plan*)

Annual Amount Requested: _____

Per Pay Period Amount Requested:_____

DISABILITY INSURANCE

Please refer to your Benefits In Brief if you have questions regarding eligibility. 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 must 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	
				☐MEDICAL ☐DENTAL ☐VISION	☐ADD ☐REMOVE
				☐MEDICAL ☐DENTAL ☐VISION	☐ADD ☐REMOVE
				☐MEDICAL ☐DENTAL ☐VISION	☐ADD ☐REMOVE
				☐MEDICAL ☐DENTAL ☐VISION	☐ADD ☐REMOVE

Team Member Signature _____ **Date** _____

WHEN COMPLETE PLEASE SEND 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
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: ☒New Hire ☐Status Change ☐Other:	☐Full Time ☐Part Time	☐Union ☐Non-Union	☐Salaried ☐Hourly