UNIVERSITY OF MICHIGAN
HEALTH-SPARROW
MICHIGAN MEDICINE

BENEFIT CHANGE IN STATUS REQUEST
PERSONAL EVENT

TEAM MEMBER NAME:_____TEAM MEMBER #:_____

EMAIL ADDRESS: _____PHONE #: _____

PERSONAL EVENT (as defined below): *Please check the changes you would like to make:*

☐**MARRIAGE** Date: _____	☐Enroll self/spouse in Health Ins ☐Enroll self/spouse in Dental Ins ☐Enroll self/spouse in Vision ☐Enroll child/step child in Health Ins ☐Enroll child/step child in Dental Ins ☐Enroll child/step child in Vision ☐Drop Health Insurance ☐Drop Dental Insurance ☐Drop Vision Insurance ☐Elect Opt Out Coverage ☐Increase HC Flexible Spending ☐Decrease HC Flexible Spending ☐Elect/Increase DC Flexible Spending ☐Drop/Decrease DC Flexible Spending ☐Elect LTD Buy Up/Down (if Appl) ☐Elect Supplemental* Life Coverage ☐Change Supplemental* Life Coverage ☐Drop Supp'l* Life Coverage ☐Elect STD Coverage (if Applicable) ☐Drop STD Coverage (if Applicable) ☐Drop LTD Buy Up/Down (if Appl) *Supplemental life coverage includes spousal and dependent life insurance **Applicable benefit forms must be completed and returned with this form**. A spousal access form must also be included if you are adding your spouse to insurance. **A copy of the marriage license is also required for any of the above changes**. **A birth certificate or certificate of adoption is required if adding children.**
☐**DIVORCE** Date: _____ -OR- ☐**DEATH** Date: _____	☐Drop spouse from Health Insurance ☐Drop spouse from Dental Insurance ☐Drop spouse from Vision Ins ☐Drop stepchildren from Health Ins ☐Drop stepchildren from Dental Ins ☐Drop stepchildren from Vision Ins ☐Elect/Increase HC Flexible Spending ☐Decrease HC Flexible Spending ☐Elect/Increase DC Flexible Spend ☐Elect Supplemental Life Coverage ☐Change Supplemental Life Coverage ☐Drop Supp'l Life Coverage ☐Elect STD Coverage (if Applicable) ☐Drop STD Coverage (if Applicable) ☐Elect LTD Buy Up/Down (if Appl) ☐Drop LTD Buy Up/Down (if Applicable) Spouse/Dependent New Address: _____ **Applicable benefit forms must be completed and returned with this form**. **A copy of the divorce decree is also required for any of the above changes.**
☐**BIRTH OR ADOPTION OF A CHILD** Date: _____	☐Enroll self/spouse in Health Ins ☐Enroll self/spouse in Dental Ins ☐Enroll self/spouse in Vision ☐Enroll child/step child in Health Ins ☐Enroll child/step child in Dental Ins ☐ Enroll child/step child in Vision ☐Elect Supplemental* Life Coverage ☐Change Supplemental* Life Coverage ☐Drop Supp'l* Life Coverage ☐Elect STD Coverage (if Applicable) ☐Drop STD Coverage (if Applicable) ☐Elect/Increase HC Flexible Spend ☐Elect/Increase DC Flexible Spend ☐Elect LTD Buy Up/Down (if Appl) ☐Drop LTD Buy Up/Down (if Appl) *Supplemental life coverage includes spousal and dependent life insurance **Applicable benefit forms must be completed and returned with this form**. **A copy of the birth certificate or certificate of adoption is also required for any of the above changes.**
☐**LOSS OF OTHER COVERAGE (you may enroll)** **-or-** ☐**GAIN OF OTHER COVERAGE (you may drop)** Date: _____	☐Enroll/Drop in Health Insurance ☐Enroll/Drop in Dental Insurance ☐Enroll/Drop in Vision Insurance ☐Enroll/Drop spouse in Health Ins ☐Enroll/Drop spouse in Dental Ins ☐Enroll/Drop spouse in Vision Ins ☐Enroll/Drop children in Health Ins ☐Enroll/Drop children in Dental Ins ☐Enroll/Drop children in Vision Ins ☐Elect/Increase Flexible Spending ☐Elect Supplemental* Life Coverage ☐Change Supp'l* Life Coverage ☐Drop Supplemental* Life Coverage ☐Elect STD/LTD Coverage (if Applicable) ☐Drop STD/LTD Coverage (if Appl) *Supplemental life coverage includes spousal and dependent life insurance **You must provide proof of loss or gain of coverage to be eligible to change your benefits.** A spousal access form must also be included if you are adding your spouse to insurance. **Applicable benefit forms must be completed and returned with this form.**

I have read and completed the above application form to the best of my ability. I understand that all Benefit enrollment/change applications must be submitted within **30 DAYS** of the qualifying status change and/or personal event. I understand that if the required documentation is not currently available, the application must still be submitted within the 30 day deadline and will be held temporarily in a pending status until the required documents are received. I authorize Sparrow to deduct any applicable premiums from my earnings in connection with the attached enrollment/change applications. Applications that have been submitted after the allowable **30-DAY** time frame will not be processed and should be elected during the announced open enrollment period.

_____ _____

Team Member Signature Date

UNIVERSITY OF MICHIGAN
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IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE TOTAL REWARDS HOTLINE AT 517 364-5333.

BENEFIT CHANGE IN STATUS REQUEST
STATUS CHANGE

TEAM MEMBER NAME: _____ TEAM MEMBER #: _____
EMAIL ADDRESS: _____ PHONE #: _____

STATUS CHANGE	**Effective Date of Change:** _____
From: (check all that apply) ☐FT ☐PT ☐PD or PT Non Ben Eligible ☐WES ☐MNA ☐UAW ☐NON UNION ☐SUPP POOL ☐SALARY ☐HOURLY	***To:*** (check all that apply) ☐FT ☐PT ☐PD or PT Non Ben Eligible ☐WES ☐MNA ☐UAW ☐NON UNION ☐SUPP POOL ☐SALARY ☐HOURLY

INCREASE IN COVERAGE

☐ **Change in Status – from Non-Benefit Eligible to Benefit Eligible** Date: _____	☐Enroll in Health Insurance ☐Enroll Spouse in Health Insurance ☐Enroll Children in Health Ins ☐Elect HC Flexible Spending ☐Elect STD Coverage (if Applicable)	☐Enroll in Dental Insurance ☐Enroll Spouse in Dental Insurance ☐Enroll Children in Dental Ins ☐Elect DC Flexible Spending ☐Elect LTD Buy Up/Down (if Applicable)	☐Enroll in Vision Insurance ☐Enroll Spouse in Vision Insurance ☐Enroll Children in Vision Ins ☐Elect Suppl'l Life Coverage
	Applicable benefit forms must be completed and returned with this form. A spousal access form must also be included if you are adding your spouse to insurance. **A copy of the marriage license is also required for any of the above changes. A birth certificate or certificate of adoption is required if adding children.**		
☐ **Change in Status – from PT Benefit Eligible to FT Benefit Eligible** Date: _____	**You must currently be enrolled in the coverage below in order to change coverage levels.** ☐Enroll Spouse in Health Insurance ☐Enroll Children in Health Ins ☐Elect Supplemental* Life Coverage ☐Elect STD Coverage (if Applicable) *Supplemental life coverage includes spousal and dependent life insurance	☐Enroll Spouse in Dental Insurance ☐Enroll Children in Dental Ins ☐Change Supplemental* Life Coverage ☐Drop STD Coverage (if Appl)	☐Enroll Spouse in Vision Insurance ☐Enroll Children in Vision Ins ☐Drop Supp'l* Life Coverage ☐Elect LTD Buy Up/Down (if Appl)
	Applicable benefit forms must be completed and returned with this form. A spousal access form must also be included if you are adding your spouse to insurance. **A copy of the marriage license is also required for any of the above changes. A birth certificate or certificate of adoption is required if adding children.**		

DECREASE IN COVERAGE

☐ **Change in Status – from Benefit Eligible to Non-Benefit Eligible** Date: _____	☐Drop DC Flexible Spending **Applicable benefit forms must be completed and returned with this form**.
☐ **Change in Status – from FT Benefit Eligible to PT Benefit Eligible** Date: _____	☐Drop Spouse Health Ins Coverage ☐ Drop Spouse Dental Ins Coverage ☐ Drop Spouse Vision Ins Coverage ☐Drop Child Health Ins Coverage ☐ Drop Child Dental Ins Coverage ☐ Drop Child Vision Ins Coverage ☐ Elect/Change Supp'l* Life Coverage ☐ Drop Supplemental* Life Coverage ☐ Change Health Insurance Plan due to a significant cost increase **Supplemental Life Coverage includes Spousal and Dependent Life Insurance* **Applicable benefit forms must be completed and returned with this form.**

I have read and completed the above application form to the best of my ability. I understand that all Benefit enrollment/change applications must be submitted within **30 DAYS** of the qualifying status change and/or personal event. I authorize Sparrow to deduct any applicable premiums from my earnings in connection with the attached enrollment/change applications. Applications that have been submitted after the allowable **30-DAY** time frame will not be processed and should be elected during the announced open enrollment period.

_____ _____
Team Member Signature Date

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE TOTAL REWARDS HOTLINE AT 517 364-5333.

BENEFIT ELECTION FORM - Status/Personal Changes

TEAM MEMBER NAME: _____ TEAM MEMBER #: _____

EMAIL ADDRESS: _____ PHONE #: _____

**** MUST BE SUBMITTED WITHIN TWO-WEEK OPEN ENROLLMENT PERIOD ****

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

MEDICAL INSURANCE

Please select the plan you would like to enroll in:

☐Gold Health Plan*
☐Silver Health Plan*
☐Bronze Health Plan (HDHP w/HSA)
☐MNA PPO Plus Plan**
☐MNA BCBS Legacy Plan**
**Not available to MNA PECSH*
***Only available to MNA PECSH*
☐Waive/Drop Coverage
☐**Union Only** 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 *(All Plans)*
☐ Team Member + Spouse *(Bronze, Silver and Gold Plans Only)*
☐ Team Member + Child(ren) *(Bronze, Silver and Gold Plans Only)*
☐ Two Person *(MNA PPO Plus and MNA BCBS Legacy Plans only)*
☐ Family Coverage *(All Plans)*

DENTAL INSURANCE

Please select the plan you would like to enroll in:

☐ Delta Dental Silver Plan
☐ Delta Dental Gold Plan
☐ Delta Dental Bronze Plan*
**Not available to MNA PECSH or MNA-HC RNs*
☐ Waive/Drop 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/change:

☐ VSP Vision Silver Plan
☐ VSP Vision Gold Plan
☐ VSP Vision Bronze Plan*
**Not available to MNA PECSH or MNA-HC RNs*
☐ Waive/Drop Coverage

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

☐ Team Member Only
☐ Two Person
☐ Family

FLEXIBLE SPENDING ACCOUNT

Please select the plan you would like to enroll in:

☐ Dependent Care Spending Account
Annual Amount Requested: _____
Per Pay Period Amount Requested:_____
☐ Medical Flexible Spending Account *(Note - not available if electing Regional Bronze Health Plan!)*
Annual Amount Requested: _____
Per Pay Period Amount Requested: _____

HEALTH SAVINGS ACCOUNT

Please select the plan you would like to enroll in/change:

☐ Health Savings Account (*Please note this option is only available when selecting the Bronze Plan*)
Annual Amount Requested: _____
Per Pay Period Amount Requested: _____

DISABILITY INSURANCE (*please review benefits assigned to your job role – disability benefits may already be provided to you automatically*)

Please select the coverage level you would like to enroll in, for pricing please see BENEFITS.UMHINSIDER.ORG:

☐ Voluntary Short-Term Disability	☐ Waive/Drop Voluntary Short-Term Disability Coverage
☐ Voluntary Long-Term Disability	☐ Waive/Drop Voluntary Long-Term Disability Coverage
☐ Buy Up Long-Term Disability Coverage	☐ Waive/Drop Buy Up Long-Term Disability Coverage
☐ Buy Down Long-Term Disability Coverage (MNA and UAW only)	☐ Waive/Drop Buy Down Long-Term Disability

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:

UM HEATLH-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 OPEN ENROLLMENT	Qualifying Event Reason ❑ New hire ❑ Status Change ❑ Other:	❑ Full Time ❑ Part Time	❑ Union ❑ Non-Union	❑ Salaried ❑ Hourly