EDWARD W. SPARROW HOSPITAL ASSOCIATION MNA EMPLOYEES HEALTH REIMBURSEMENT ARRANGEMENT

Managed for the Trustees by: TIC MIDWEST

ENROLLMENT FORM & YEARLY DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

Member's Name | Birth date | Member ID or SSN

Street Address

City | State | Zip Code | Telephone Number (including area code)

MARITAL STATUS (Check One): ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widow** ☐ **Separated**

NOTE: If you are married, please submit a copy of your marriage certificate, if you have dependent children, please submit a copy of their birth certificate(s). If you have previously provided this information to TIC, please disregard.

-Please list all eligible dependents below-

Spouse's Name | Birth date | Social Security No.

Dependent's Name	Relationship	Birth date	Social Security No.

PLEASE READ CAREFULLY AND SIGN BELOW

I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

NOTE: IN THE EVENT OF THE MEMBER'S DEATH, THE MEMBER'S LEGAL SPOUSE AND ELIGIBILE DEPENDENT CHILDREN ARE THE DESIGNATED BENEFICIARIES.

Member's Signature: **Date:**

Spouse's Signature: **Date:**

Return this form to: EDWARD W. SPARROW HOSPITAL ASSOCIATION
MNA EMPLOYEES HRA
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Lansing MI 48917
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