



Benefits Selection Form-SSOM

Last Name:		First Name:		Social Security #: (Last 4-digits)	
Home Address:		City/State/Zip		Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>	
				Date of Birth:	
Home phone:		Work phone:			
Hire Date:	Faculty: <input type="checkbox"/> Staff <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/>			ID #	
Department:	Male <input type="checkbox"/> Female <input type="checkbox"/>				
1. Health Plan Options – PPO					Employer Only
Loyola Advantage PPO (BCBS) <input type="checkbox"/>		Coverage level for health Single <input type="checkbox"/> Family <input type="checkbox"/> Single+Child(ren) <input type="checkbox"/> Single+LDA <input type="checkbox"/> Single+Spouse <input type="checkbox"/> Single+LDA+Child(ren) <input type="checkbox"/> NO Coverage <input type="checkbox"/>			Group: Section: Effective date:
2. Dental Plan Options (choose one)					Employer Only
Delta Dental PPO <input type="checkbox"/>		Coverage level for dental Single <input type="checkbox"/> Family <input type="checkbox"/> Single+Child(ren) <input type="checkbox"/> Single+LDA <input type="checkbox"/> Single+Spouse <input type="checkbox"/> Single+LDA+Child(ren) <input type="checkbox"/> NO Coverage <input type="checkbox"/>			Group: Section: Effective date:
Guardian/First Commonwealth DHMO <input type="checkbox"/> Include dentist code:					
3. Employee/Dependent Required Information					
Name: (Last, First, M.I.)		Social Security Number		DOB M/D/Y	M/F
Employee:					
Spouse/LDA:					
Child:					
Child:					
Child:					
Child:					
4. Are you or your family members covered by another group health insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide: Policy #: _____ ID #: _____ Name of insured person: _____ Employed by: _____			5. Are you or your family members covered by Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Medicare enrollee: _____ HIC# _____ Start date: _____		

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 (continued)

STOP 6. Flexible Spending Account

Enrollment in FSA accounts is directly through Benefit Express See On-line benefits booklet for details. To enroll go to www.loyolaexpress.com. Remember, enrollment in FSA accounts must be done annually.

STOP 7. Long Term Care-CNA Insurance

Enrollment in long term care benefits is directly through CNA Insurance. See On-line benefits booklet for details. To enroll go to www.ltcbenefits.com

8. Vision Plan Options

Vision Service Plan Coverage level for vision
 Always Vision Single Single+Spouse Single+Child(ren) Family
 Single+LDA Single+LDA+Child(ren) No coverage Hyatt Legal Services
 Yes No coverage

9. Life Insurance Employer only: Grp: Sec: Amt:
 Total amount:

Supplemental Life Yes <input type="checkbox"/> No coverage <input type="checkbox"/> Select in increments of your salary. 1x salary <input type="checkbox"/> 2x salary <input type="checkbox"/> 3x salary <input type="checkbox"/> 4x salary <input type="checkbox"/> 5x salary <input type="checkbox"/> Your selection may be subject to Evidence of Insurability provisions. Please see On-line Benefits Booklet for more information	Dependent Life Spouse Yes <input type="checkbox"/> No Coverage <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$35,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$45,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/>	Dependent Life Child(ren) Flat \$5,000 coverage Yes <input type="checkbox"/> No Coverage <input type="checkbox"/>
	Accidental Death and Dismemberment Level of coverage: Employee <input type="checkbox"/> Employee+Family <input type="checkbox"/> No Coverage <input type="checkbox"/> Coverage Amounts: \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/>	

10. Beneficiary Designation (provide name of individual and relationship to you)

Primary:
 Secondary:

11. Qualifying Life Event Changes

Reason for Event Change (select below):
 New Hire Marriage
 Birth or Adoption
 Divorce Loss of Prior Insurance Coverage
 Name Change – List prior name: _____

Date of Event Change: _____

To add or remove any dependent(s) complete Section 3 for those dependent(s) change(s) only

Mail completed forms to: Loyola University Health Systems- Human Resources - Medical Center, 2160 S. First Avenue, Maywood, IL 60153, or via enter-campus mail to Human Resources-Benefits Dept., Mulcahy Bldg. 106, Room 1605, LUMC

I apply for the coverage indicated and authorize Loyola University Chicago to deduct the cost of my selected coverage from my pay. My health and dental contribution will be reduced in pre-tax dollars unless otherwise indicated in writing to Human Resources Dept. I understand that benefits are available subject to terms and conditions specified in the benefit description. Upon presentation of the original or copy of this form, I authorize any medical professional, hospital, clinic or other medically related facility, government agency or other person or firm to provide information (including copies of records) concerning advice, care or treatment provided to me and/or my covered dependents including without limitation, information related to mental illness, use of drugs or alcohol, to the authorized representatives involved in evaluating, determining or administering claims for insurance benefits for me and my covered dependents. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed through the terms and conditions of the policy. Additionally, I certify that all of the information which I have submitted is accurate to the best of my knowledge. Failure to provide accurate information may result in suspension of benefit eligibility.

Signature of Employee _____ **Date** _____