Retiree Information Update Form

LAST NAME:	FIRST NAME:	MIDDLE Initial:

Birth Date: (__ __/__ __/__ __ __ __) (M M/ D D/ Y Y Y Y)	Sex: M F	Last 4 digits of SSN# XXX-XX-_ _ _ _	Phone Number: ( )

Permanent Residence Street Address:

City:	State:	Zip Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address:
City: State: Zip Code:

Are you a retiree of Loyola University yes ☐ no ☐

If no, please provide the deceased retiree's name_____

Complete for any Spouse or dependent Child covered under your plan

Name of Dependent	Dependent Social Security Number Last 4 digits ONLY	Date of Birth	Sex	Relationship	Is person covered by Medicare?

Emergency Contact: Phone Number: Relationship to You:

Please provide your Medicare Insurance Information exactly as listed on your Red, White and Blue Medicare card. (Also send a copy of your Medicare card.)

Retiree Information	Spouse Information
Name: _____	Name: _____
Medicare Claim Number: Sex: __	Medicare Claim Number: Sex: __
__ __ __ - __ __ - __ __ __ __ __ __	__ __ __ - __ __ - __ __ __ __ __ __
Is entitled to: Effective Date	Is entitled to: Effective Date
Hospital (Part A) _____	Hospital (Part A) _____
Medical (Part B) _____	Medical (Part B) _____

Signature: _____ Date: _____

Office Use Only

Group Name: _____ Group Number: _____
Contact Name: _____ Authorized Signature: _____
Phone Number: _____ Coverage Effective Date: _____

Return to the following address:
Loyola University Chicago – Benefits & Compensation
820 N. Michigan Ave., Suite 820, Chicago, IL 60611