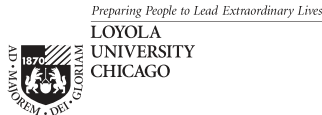


**Benefits Selection Form-2007-LUC**



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"/>			
<b>1. Health Plan Options – PPO and HMO Plans (choose one)</b>					Employer Only
BC/BS Option I PPO <input type="checkbox"/>		Coverage level for health			Group:
BC/BS LU Preferred PPO <input type="checkbox"/>		Single <input type="checkbox"/> Family <input type="checkbox"/>			Section:
HMO Illinois <input type="checkbox"/>		Single+Child(ren) <input type="checkbox"/> Single+LDA <input type="checkbox"/>			Effective date:
		Single+Spouse <input type="checkbox"/> Single+LDA+Child(ren) <input type="checkbox"/>			
		NO Coverage <input type="checkbox"/>			
<b>2. Dental Plan Options (choose one)</b>					Employer Only
Delta Dental PPO <input type="checkbox"/>		Coverage level for dental			Group:
		Single <input type="checkbox"/> Family <input type="checkbox"/>			Section:
Guardian/First Commonwealth DHMO <input type="checkbox"/>		Single+Child(ren) <input type="checkbox"/> Single+LDA <input type="checkbox"/>			Effective date:
Include dentist code:		Single+Spouse <input type="checkbox"/> Single+LDA+Child(ren) <input type="checkbox"/>			
		NO Coverage <input type="checkbox"/>			
<b>3. Employee/Dependent Required Information</b>					
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:		
<b>STOP! 6. Flexible Spending Account</b>					
Enrollment in FSA accounts is directly through Benefit Express See On-line benefits booklet for details. To enroll go to <a href="http://www.loyolaexpress.com">www.loyolaexpress.com</a> . Remember, enrollment in FSA accounts must be done annually.					
<b>STOP! 7. Long Term Care-CNA Insurance</b>					
Enrollment in long term care benefits is directly through CNA Insurance. See On-line benefits booklet for details. To enroll go to <a href="http://www.ltcbenefits.com">www.ltcbenefits.com</a>					
<b>8. Vision Plan Options</b>					
Vision Service Plan <input type="checkbox"/>		Coverage level for vision			Hyatt Legal Services
Always Vision <input type="checkbox"/>		Single <input type="checkbox"/> Single+Spouse <input type="checkbox"/> Single+Child(ren) <input type="checkbox"/> Family <input type="checkbox"/>			Yes <input type="checkbox"/> No coverage <input type="checkbox"/>
		Single+LDA <input type="checkbox"/> Single+LDA+Child(ren) <input type="checkbox"/> No coverage <input type="checkbox"/>			
<b>9. Life Insurance</b>					
Supplemental Life Yes <input type="checkbox"/> No coverage <input type="checkbox"/> Select in increments of your salary.		Employer only: Grp: Sec: Amt: Total amount:		Dependent Life Spouse Yes <input type="checkbox"/> No Coverage <input type="checkbox"/>	
1x salary <input type="checkbox"/>		\$5,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/>		Dependent Life Child(ren) Flat \$5,000 coverage Yes <input type="checkbox"/>	
2x salary <input type="checkbox"/>		\$10,000 <input type="checkbox"/> \$35,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/>		No Coverage <input type="checkbox"/>	
3x salary <input type="checkbox"/>		\$15,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/>			
4x salary <input type="checkbox"/>		\$20,000 <input type="checkbox"/> \$45,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/>			
5x salary <input type="checkbox"/>		\$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/>			
Your selection may be subject to Evidence of Insurability provisions. Please see On-line Benefits Booklet for more information		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"/>			
<b>10. Beneficiary Designation (provide name of individual and relationship to you)</b>					
Primary: Secondary:					
<b>11. Qualifying Life Event Changes</b>					
Reason for Event Change (select below): New Hire <input type="checkbox"/> Marriage <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Loss of Prior Insurance Coverage <input type="checkbox"/> Name Change <input type="checkbox"/> – List prior name:			Date of Event Change: _____  To add or remove any dependent(s) complete Section 3 for those dependent(s) change(s) only		
<b>Mail completed forms to: Loyola University Chicago, 820 N. Michigan Avenue, Chicago, IL 60611, or send via inter-office campus mail to Human Resources, Lewis Towers, 8th Floor, Water Tower Campus</b>					
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 _____