



LOYOLA UNIVERSITY CHICAGO RETIREE MEDICAL PLAN ENROLLMENT FORM

EFFECTIVE DATE:	GROUP NUMBER:	SECTION #:	SOCIAL SECURITY # :
LAST NAME:		FIRST NAME:	M.I.
BIRTH DATE: <small>(M M / D D / Y Y Y Y)</small>	SEX: M F	PHONE NUMBER: <small>()</small>	HIRE DATE:
RETIREMENT DATE:			
PERMANENT RESIDENCE STREET ADDRESS:			
CITY:		STATE:	ZIP CODE:

Are you covered under the Loyola Univ. Retiree Medical plan and also covered by Medicare? No Yes

If you answered Yes to the question above, please complete all Medicare information below:

HIC # _____ Medicare B: _____ ESRD DIALYSIS: _____ DISABILITY: _____

MEDICARE A: Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___

Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

I HAVE ELECTED RETIREE MEDICAL COVERAGE FOR :

RETIREE UNDER AGE 65

RETIREE ONLY

RETIREE + SPOUSE - BOTH UNDER 65

RETIREE + CHILD(REN)

RETIREE & SPOUSE UNDER 65 + CHILD(REN)

RETIREE OVER AGE 65

RETIREE ONLY

RETIREE + SPOUSE - BOTH OVER 65

RETIREE + CHILD(REN)

RETIREE & SPOUSE OVER 65 + CHILD(REN)

ONE OVER AGE 65 / ONE UNDER AGE 65

RETIREE UNDER 65 + SPOUSE OVER 65

RETIREE OVER 65 + SPOUSE UNDER 65

RETIREE OVER 65 + SPOUSE UNDER 65 + CHILD(REN)

RETIREE UNDER 65 + SPOUSE OVER 65 + CHILD(REN)

***** PLEASE NOTE *****

If you or any of your covered dependents on this plan are Medicare Eligible, each Medicare Eligible member must also complete the Blue Medicare Rx Enrollment Form, to obtain Medicare Part D prescription drug coverage under this plan. If you enroll in another Medicare Part D plan, Loyola University will cancel both your medical and prescription drug coverage under this plan.

DEPENDENT INFORMATION

Please complete the information listed below for all dependents that you wish to enroll in the Loyola University Chicago Retiree Medical Plan. Please note, if enrolling a Legally Domiciled Adult (LDA), you must also complete an LDA Certification Form, which is available thru Human Resources. You may only enroll one other adult-either a spouse OR a Legally Domiciled Adult. (Other rules governing LDA enrollment may apply- Please contact Human Resources for more information.)

SPOUSE'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER

Is your spouse covered under the Loyola Univ. Retiree Medical plan and also covered by Medicare? No Yes

If you answered Yes to the question above, please complete all Medicare information below:

HIC # _____ Medicare B: _____ ESRD DIALYSIS: _____ DISABILITY: _____

MEDICARE A: Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___

Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

CHILD'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER
Child 1:			
Is this child covered under the Loyola Univ. Retiree Medical plan and also covered by Medicare? No <input type="checkbox"/> Yes <input type="checkbox"/> If you answered Yes to the question above, please complete all Medicare information below:			
HIC # _____	Medicare B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___
CHILD'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER
Child 2:			
Is this child covered under the Loyola Univ. Retiree Medical plan and also covered by Medicare? No <input type="checkbox"/> Yes <input type="checkbox"/> If you answered Yes to the question above, please complete all Medicare information below:			
HIC # _____	Medicare B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___
CHILD'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER
Child 3:			
Is this child covered under the Loyola Univ. Retiree Medical plan and also covered by Medicare? No <input type="checkbox"/> Yes <input type="checkbox"/> If you answered Yes to the question above, please complete all Medicare information below:			
HIC # _____	Medicare B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___
OTHER INSURANCE INFORMATION			
If you or any of your family members have other group coverage, PLEASE COMPLETE ALL INFORMATION BELOW:			
Health: Group Policy #: _____			
Insured's Name: _____		Employed By: _____	
Insurance Co. Name: _____		Address: _____	
Ins. Co. Phone#: _____		City, State, Zip: _____	
<input type="checkbox"/> I APPLY FOR COVERAGE AS INDICATED ABOVE, for which I am eligible under the eligibility rules set forth by Loyola University Chicago. I have read the above statements and verify they are true and complete to the best of my knowledge. I understand that I am responsible for making the required monthly premium payments for this insurance coverage.			
<input type="checkbox"/> I AM DECLINING ENROLLMENT IN THE LOYOLA UNIVERSITY CHICAGO RETIREE MEDICAL PLAN. I understand that if I decline enrollment at this time, I will not have the opportunity to enroll in this medical insurance plan at any later date.			
SIGNATURE:			DATE: