Benefits Department
Human Resources | Water Tower Campus
Loyola University Chicago | 820 N Michigan Ave, Suite 820 | Chicago IL 60611
Office: 312-915-6175 | Fax: 312-915-7612 | Email: Benefits@luc.edu

Spouse/Legally Domiciled Adult (LDA) Surcharge Waiver Form 2017

Employee Last Name	First Name	M.I.	Employee Number (Found on Paycheck)

Home Street Address	Apt/Unit	City	State	Zip

Spouse/LDA Full Legal Last Name	Spouse/LDA Full Legal First Name	Spouse/LDA Employers Name	Spouse/LDA Employers Address

Loyola University Chicago continually strives to maintain the best possible medical coverage at the most reasonable cost for our employees. To help us accomplish this goal, we closely monitor our eligibility criteria for health care coverage. Faculty and staff who have a spouse or Legally Domiciled Adult (LDA) on the Loyola Medical Plan, will automatically be assessed a $50 monthly spousal/LDA surcharge. The surcharge will only apply if your spouse or LDA works full-time and is eligible for medical coverage through his or her own employer but chooses to enroll in the Loyola University medical plan as his/her primary plan. **However if your spouse/LDA meets the criteria below you can avoid the surcharge by completing this certification form and returning it to Human Resources by e-mail at Benefits@luc.edu, or fax 312-915-7612**.

The surcharge will automatically be assessed for employees enrolling in Employee + Spouse, Employee + LDA, Family, or Employee + LDA + Child(ren) medical coverage, unless you actively notify Benefits by submitting this completed form within 31 days of your date of hire or 31 days of your benefit life event change. If possible please submit this form prior to enrolling in benefits to ensure you receive the proper rate. **Surcharge waivers submitted as a result of a qualifying life event will take effect the first of the month following the requested change.**

I am requesting the waiver because:

☐ **I am a new hire/ had a job change**. Date of Hire/Job Change Effective Date: _____

☐ **My spouse/LDA or I have a qualifying life event**. Life Event Change Date: _____

I request a lower medical premium because: *(Check the box that applies)*

☐	My covered spouse/LDA is not employed.
☐	My covered spouse/LDA is self-employed.
☐	My covered spouse/LDA is employed full-time but is not eligible for medical coverage through his/her employer.
☐	My covered spouse/LDA is employed full-time or part-time at Loyola University Chicago.
☐	My covered spouse/LDA works part time (even if eligible for coverage).

Note: You are required to inform Human Resources of any changes in the availability of coverage listed above for your spouse/LDA at another employer, within 31 days of such change. All documentation submitted after the effective date of change will take place the 1st of the following month. If you or your spouse has had a qualifying life event and you are adding your spouse/LDA to your plan please complete this form and the Benefit Change Form or the LDA Certification form and submit to the Benefits Department at Water Tower Campus.

I hereby certify that the information provided by me on this form is true and correct. I understand that I am required to inform the Benefits Department of any change in the availability of coverage for my spouse/LDA at another employer, within 31 days of such change. I understand that as a participant, any misrepresentation or omission of facts on this certification form is a breach of Loyola University Chicago's Code of Conduct and is sufficient cause for disciplinary action, including but not limited to termination of employment, as well as reduction or loss of benefit or reversal of claim payments.

Employee Signature: _____ **Date:** _____ **Submit Form**

You must complete this form and return it to Human Resources @ Water Tower Campus via fax at 312-915-7612, or scan and e-mail to Benefits@luc.edu. Please do not send this form via campus mail or US mail. If you do not return this form certifying you have an exemption the higher monthly premium will apply for the 2017 plan year.

For Use of the Benefits Department Only **Form Received:** _____ **Processed By:** _____ **Effective Date:** _____ **Ben 5 Completed:** ____