



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/LDA Surcharge

Waiver Form 2016

Employee Last Name	First Name	M.I.	6 Digit Paycheck ID Number		
Home Street Address		Apt/Unit	City	State	Zip
Spouse/LDA Last Name	Spouse/LDA 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. Effective January 1, 2016 **an adjusted health insurance premium** will 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.

The adjusted health insurance premium will automatically be assessed for employees enrolling in Single + Spouse, Single + LDA, Family, or Single + 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. All changes submitted 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)*

<input type="checkbox"/>	My covered spouse/LDA is not employed.
<input type="checkbox"/>	My covered spouse/LDA is self-employed.
<input type="checkbox"/>	My covered spouse/LDA is employed full-time but is not eligible for medical coverage through his/her employer.
<input type="checkbox"/>	My covered spouse/LDA is employed full-time or part-time at Loyola University Chicago.
<input type="checkbox"/>	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. **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: _____

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 2016 plan year.

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