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

Benefit Enrollment Form 2017

New Enrollment and Life Event Changes

1. PERSONAL INFORMATION PLEASE PRINT CLEARLY

☐ Current or ☐ New Hire

Employee Number

Pay Frequency: ☐ Biweekly or ☐ Monthly

Employee Legal Last Name	Legal First Name	M.I.	Gender	Campus
			☐Male ☐ Female	☐Lakeside ☐HSD-Health Science Div.

Home Street Address	Apt/Unit	City	State	Zip

Date of Birth	Date of Hire	Home/Cell Phone	5 Digit Work Extension	Work Email

2. QUALIFYING LIFE EVENT TYPE

Documentation must be submitted to support your qualifying life event. Please see benefit booklet online for details.

☐ New Employee or Newly Benefits Eligible ☐ Birth ☐ Adoption or Legal Guardianship ☐ Marriage
☐ Divorce ☐ Death of Spouse or Dependent ☐ Employee, Spouse or Dependent Gained or Loss other Coverage ☐ Other

3. ELECT OR CHANGE YOUR COVERAGE FOR Medical, Dental and Vision.

Choose one coverage level for each benefit, coverage level can vary by benefit

Coverage	Provider	Coverage Level
Medical Coverage ☐ Enroll ☐ Keep the Same ☐ End Coverage ☐ Waive	Only One Provider **Loyola Advantage PPO BCBS**	☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Employee + LDA ☐ Employee + LDA + Child(ren) ☐ Family Coverage (Includes Spouse and Children)
Dental Coverage ☐ Enroll ☐ Keep the Same ☐ End Coverage ☐ Waive	Choose Dental Plan Choose One Only ☐ Delta Dental (PPO) ☐Guardian/1st Com. Of IL (DHMO)	☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Employee + LDA ☐ Employee + LDA + Child(ren) ☐ Family Coverage (Includes Spouse and Children)
Vision Coverage ☐ Enroll ☐ Keep the Same ☐ End Coverage ☐ Waive	Only One Provider **Vision Service Providers (VSP)**	☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Employee + LDA ☐ Employee + LDA + Child(ren) ☐ Family Coverage (Includes Spouse and Children)

4. ADD/DROP DEPENDENTS

(if currently enrolled only put the names of the dependents you wish to add or drop, new hires add dependents wanted on plan, use back of form if needed)

Dependents must have their full legal first and last names along with their complete date of birth and entire social security number or IRS Tax Identification Number (ITIN).

Last Name (if different from employee)	First Name	MI	Gender	Date of Birth	Relationship	Social Security Number/ITIN
			☐ Male ☐ Female			
Medical Coverage ☐ Enroll ☐Drop	Dental Coverage ☐ Enroll ☐Drop		Vision Coverage ☐ Enroll ☐Drop		Child Life ☐ Enroll ☐Drop	

Last Name (if different from employee)	First Name	MI	Gender	Date of Birth	Relationship	Social Security Number/ITIN
			☐ Male ☐ Female			
Medical Coverage ☐ Enroll ☐Drop	Dental Coverage ☐ Enroll ☐Drop		Vision Coverage ☐ Enroll ☐Drop		Child Life ☐ Enroll ☐Drop	

Last Name (if different from employee)	First Name	MI	Gender	Date of Birth	Relationship	Social Security Number/ITIN
			☐ Male ☐ Female			
Medical Coverage ☐ Enroll ☐Drop	Dental Coverage ☐ Enroll ☐Drop		Vision Coverage ☐ Enroll ☐Drop		Child Life ☐ Enroll ☐Drop	

Last Name (if different from employee)	First Name	MI	Gender	Date of Birth	Relationship	Social Security Number/ITIN
			☐ Male ☐ Female			
Medical Coverage ☐ Enroll ☐Drop	Dental Coverage ☐ Enroll ☐Drop		Vision Coverage ☐ Enroll ☐Drop		Child Life ☐ Enroll ☐Drop	

Last Name (if different from employee)	First Name	MI	Gender	Date of Birth	Relationship	Social Security Number/ITIN
			☐ Male ☐ Female			
Medical Coverage ☐ Enroll ☐Drop	Dental Coverage ☐ Enroll ☐Drop		Vision Coverage ☐ Enroll ☐Drop		Child Life ☐ Enroll ☐Drop	

Last Name (if different from employee)	First Name	MI	Gender	Date of Birth	Relationship	Social Security Number/ITIN
			☐ Male ☐ Female			
Medical Coverage ☐ Enroll ☐Drop	Dental Coverage ☐ Enroll ☐Drop		Vision Coverage ☐ Enroll ☐Drop		Child Life ☐ Enroll ☐Drop	

5. HYATT LEGAL - $15.00 a Month

☐ Enroll or ☐ Waive

6. LONG TERM CARE

Enrollment in Long Term Care benefits directly through Life Secure. See online benefits booklet for details. Click here for more information.

7. FLEXIBLE SPENDING ACCOUNTS

Only complete this section if you are unable to sign up for FSA or DCA via loyolaexpress.com.

Health Care Flexible Spending Account (FSA)

Available to benefits eligible employees. Eligible expenses must be incurred between January 1st and December 31st. FSA elections are not automatically renewed; elections expire December 31st of election year. This account is used for eligible health care related expenses for you and your dependents. **You must elect new FSA amounts for the following calendar year during open enrollment. All new elections and or changes are effective the 1st of the following month as a new hire or the date of the qualifying life event. Please note: changes to your FSA election must be consistent with your qualifying life event.**

Enrollment

☐ **Enroll as a new hire or newly benefits eligible employee** ☐ **I do NOT want a FSA-Health Care Account**

Qualifying Life Event Changes for those that are currently enrolled in FSA-Health Care Account

☐ **I would like to increase my current FSA Amount** ☐ **I would like to decrease my current FSA amount** ☐ **I want to end my FSA Account**

Annual Election Amount (minimum $240.00, 2017 maximum $2600.00) $ _____

Dependent Care Flexible Spending Account (DCA)

Available to benefits eligible employees. Eligible expenses must be incurred between January 1st and December 31st. DCA elections are not automatically renewed; elections expire December 31st of election year. This account is used for childcare expenses such as day care, day camp, etc. for 13 year olds and under. You must elect new DCA amounts for the following calendar year during open enrollment. **All new elections are effective January 1st. All new elections and or changes are effective the 1st of the following month as a new hire or the date of the qualifying life event. Please note: changes to your DCA election must be consistent with your qualifying life event.**

Enrollment

☐ **Enroll as a new hire or newly benefits eligible employee** ☐ **I do NOT want a FSA-Dependent Care Account**

Qualifying Life Event Changes for those that are currently enrolled in FSA-Dependent Care Account

☐ **I would like to increase my current FSA Amount** ☐ **I would like to decrease my current FSA amount** ☐ **I want to end my FSA Account**

Annual Election Amount (minimum $240.00, 2017 maximum $5000.00) $ _____

8. LIFE INSURANCE

Beneficiary additions and changes can be made online at any time using Employee Self-Service at Lawson.luc.edu

Supplemental Life –Term Life

☐ Enroll ☐ Waive ☐ Keep the Same ☐ Change ☐ End Coverage

☐ *1 Times Annual Salary*
☐ *2 Times Annual Salary*
☐ *3 Times Annual Salary**
☐ *4 Times Annual Salary**
☐ *5 Times Annual Salary**

**Requires Evidence of Insurability*

If newly hired/benefits eligible, you may elect supplemental life insurance up to 2x your annual salary without EOI. **Any new election or increase to coverage made after your new hire enrollment period will require EOI. *Reliance EOI Form***

Dependent Life Spouse

☐ Enroll ☐ Waive ☐ Keep the Same ☐ Change ☐ End Coverage

☐ *$5,000*
☐ *$10,000*
☐ *$15,000*
☐ *$20,000*
☐ *$25,000*
☐ *$30,000**
☐ *$35,000**
☐ *$40,000**
☐ *$45,000**
☐ *$50,000**
☐ *$60,000**
☐ *$70,000**
☐ *$80,000**
☐ *$90,000**
☐ *100,000**

**Requires Evidence of Insurability*

You may purchase life insurance coverage for your spouse if you elect supplemental life insurance for yourself. Also you CANNOT purchase more life insurance on your spouse than you have purchased on yourself.

Dependent Life Children

☐ Enroll ☐ Waive ☐ Keep the Same ☐ End Coverage

Flat $5,000 coverage for each child under 26 years of age. Dependents that are currently enrolled will be terminated from Child Life Coverage at the age of 26.

Accidental Death and Dismemberment - Level of Coverage (choose one):

☐ Enroll ☐ Waive ☐ Keep the Same ☐ Change ☐ End Coverage

Coverage Amounts (choose one):
☐ Employee or ☐ Employee + Family

Coverage Amounts (choose one):
☐ $50,000 ☐ $100,000 ☐ $200,000 ☐ $300,000

I am authorizing Loyola University Chicago to take the required deductions from my pay for my benefit elections. My health, vision and dental contributions will be reduced in pre-tax dollars unless otherwise indicated in writing to the Human Resources Dept. I understand that benefits are available subject to terms and conditions specified in the benefit description. *Additionally, I certify that all the information submitted is accurate to the best of my knowledge and that I will not be able to make changes to my benefit choices during the Plan Year (January 1 through December 31) unless I experience a qualifying life change.*

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

You must complete this form, submit supporting documentation 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.