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) Premium Waiver Form

Employee Last Name	First Name	M.I.	Employee 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. Faculty and staff who have a spouse or Legally Domiciled Adult (LDA) on a Loyola Medical Plan, will automatically be assessed a $100 monthly spousal/LDA Premium. The premium 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. **You can avoid the Premium by completing this certification form and returning it to Human Resources by e-mail at Benefits@luc.edu, or fax 312-915-7612**.

The premium 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 benefit life event change. Premium 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:

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

I request a lower medical premium because: *(Check the one 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. If you or your spouse had a qualifying life event and you are adding your spouse/LDA to your Plan, please complete this form, the Benefit Change Form, and submit to the Human Resources.

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 which may result in disciplinary action leading up to and including termination. Additionally the consequences of a false statement, if discovered, are that you would lose all university contribution to your health premium.

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 2018 plan year.

Submit Form

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