Benefits Department
Human Resources | Water Tower Campus
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Benefit Enrollment Form 2018

New Enrollment and Life Event Changes

Please complete electronically and/or print clearly and make sure to sign and submit this form to your Loyola HR/Benefits Office. Keep a copy for your records. You may refer to the Loyola Benefits Handbook and plan guides for details at www.luc.edu /hr

PERSONAL INFORMATION PLEASE PRINT CLEARLY

Employee Legal Last Name	Legal First Name	M.I.	☐Male ☐ Female Gender	Date of Birth

Home Street Address	Apt/Unit	City	State	Zip

Employee #	Date of Hire	Home/Cell Phone	Work Number	Work Email	☐Biweekly ☐ Monthly Pay Frequency

ENROLLMENT INFORMATION

☐ **New Employee Date of Hire:** _____ ☐ **Current Employee Newly Benefits Eligible Date of Change:** _____

☐ **Change in Status – Reason (select one):** ☐ **Birth or Adoption** ☐ **Marriage** ☐ **Loss of Other Coverage** ☐**Divorce**
☐ **Death of Covered Dependent** ☐ **Spouse Employment Loss** ☐ **Legal Guardianship** ☐ **Other:** _____

Event Date: _____ (Request for coverage must be made within 31 days of qualified event. And documentation must support event)

☐ **Annual Enrollment-For coverage effective January 1st.**

TOBACCO USE ATTESTATION and SPOUSE/LDA PREMIUM ACKNOWLEDGEMENTS

Tobacco Use Certification (Applies to Faculty/Staff members only)

If you are in enrolling in any Loyola Medical Insurance Plan please indicate your tobacco use status below by selecting the appropriate answer. Please note: tobacco use applies to all types of tobacco products that are smoked (cigarettes, cigars, cigarillos, pipes, electronic cigarettes, vaping products or hookah), applied to the gums (chewing tobacco, dip, and loose tobacco) and/or inhaled (snuff).

I understand that if I am found to be providing untruthful information on this certification, or if I fail to report a change in tobacco usage, it may result in disciplinary action leading up to and including termination of employment. Additionally, the consequences of a false statement, if discovered, are that you would lose all university contribution to your health premium.

☐ I **have NOT** used any form of tobacco in the last 3 months.
☐ I **HAVE** used tobacco in the last 3 months. **A $50.00 premium will be added to your health insurance premiums.**

Spousal/LDA Health Insurance Premium Acknowledgement

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/LDA works full-time and is eligible for medical coverage through their own employer but chooses to enroll in the Loyola University Chicago medical plan.

I understand that if I am found to be providing untruthful information on this certification, or if I fail to report a change in my spouse's/LDA's medical coverage eligibility, it may result in disciplinary action leading up to and including termination of employment. Additionally, the consequences of a false statement, if discovered, are that you would lose all university contribution to your health premium.

☐ **YES**, my spouse/LDA is eligible for another employer's medical plan. **I understand that $100 premium will be added to my health insurance premium.**
☐ **NO**, my spouse/LDA is not eligible for another employer's medical plan. **Select one reason**: ☐ My covered spouse / LDA is not employed ☐My covered spouse / LDA is self-employed ☐ My covered spouse / LDA is employed at Loyola University Chicago ☐ My covered spouse / LDA is employed full-time but is not eligible for medical coverage through his / her employer ☐ My covered spouse / LDA works part-time (even if eligible for coverage)

COVERAGE ELECTIONS-Medical, Dental and Vision Choose one coverage level for each benefit, coverage level can vary by benefit

Medical Insurance Plans (Please Choose One Plan Only)

☐ **I want to waive Health Insurance Coverage**

☐ **Loyola Advantage PPO 1**
☐ **Enroll** ☐ **Keep the Same** ☐ **Change Coverage** ☐ **End Coverage**

☐ **Loyola Advantage PPO 2** New Plan for 2018
☐ **Enroll** ☐ **Keep the Same** ☐ **Change Coverage** ☐ **End Coverage**

☐ **Employee Only**
☐ **Employee + Child(ren)**
☐ **Employee + Spouse**
☐ **Employee + LDA**
☐ **Employee + LDA + Child(ren)**
☐ **Family Coverage** (Includes Spouse and Children)

Dental Insurance Plans (Please Choose One Plan Only)

☐ **I want to waive Dental Insurance Coverage**

☐ **Delta Dental (PPO)**
☐ **Enroll** ☐ **Keep the Same** ☐ **Change Coverage** ☐ **End Coverage**

☐ **Guardian 1st Commonwealth (DHMO)** Chicagoland, Northern Illinois, NW Indiana Only
☐ **Enroll** ☐ **Keep the Same** ☐ **Change Coverage** ☐ **End Coverage**

☐ **Employee Only**
☐ **Employee + Child(ren)**
☐ **Employee + Spouse**
☐ **Employee + LDA**
☐ **Employee + LDA + Child(ren)**
☐ **Family Coverage** (Includes Spouse and Children)

Vision Insurance Plan

☐ **I want to waive Vision Insurance Coverage**

Vision Service Providers (VSP) (PPO)
☐ **Enroll** ☐ **Keep the Same** ☐ **End Coverage**

☐ **Employee Only** ☐ **Employee + Child(ren)** ☐ **Employee + Spouse** ☐ **Employee + LDA**
☐ **Employee + LDA + Child(ren)** ☐ **Family Coverage (Includes Spouse and Children)**

LIFE AND DISABILITY INSURANCE Basic Life insurance coverage is provided at no cost to eligible faculty and staff at 1 ½ times your salary not to exceed $500,000.

Voluntary Supplemental Life Insurance- Term Life

Faculty and Staff, you may elect supplemental life insurance up to 5 times your annual salary or up to a maximum of $500,000 are are subject to EOI. New hires or newly benefits eligible employees may elect up to $250,000 without an EOI. **Any new election or increase to coverage made after your new hire enrollment period will require EOI.** ***Reliance EOI Form***

☐ **Enroll** ☐ **Change** **I want to elect _____ times* my salary** ☐ **Keep the Same** ☐ **End Coverage** ☐ **Waive**

**May Require Evidence of Insurability if the times/amount elected exceeds $250,000.*

Spouse Supplemental Life

Eligible Faculty and Staff can elect supplemental life insurance for their spouse provided that you are also enrolled in supplemental life coverage. Spousal coverage may not exceed 100% of the Faculty and Staff employee's supplemental coverage. Evidence of Insurability required for elected amounts over $25,000. Legally Domiciled Adults (LDA's) are not eligible for coverage.

☐ **Enroll** ☐ **Waive** ☐ **Keep the Same** ☐ **Change Amount** ☐ **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*

Child Supplemental Life

Eligible Faculty and Staff can elect supplemental life insurance for their child (ren) provided that you are also enrolled in supplemental life coverage for yourself. Child from birth to 6 months have a benefit of $1000 and dependents over 6 months have a $5000.00 benefit until the age of 26.

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

Accidental Death and Dismemberment for you and or your family. Legally Domiciled Adults (LDA's) are not eligible for coverage.

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

Coverage Type (choose one)
☐ **Employee OR** ☐ **Family**

Coverage Amount (choose one)
☐ **$50,000** ☐ **$100,000** ☐ **$200,000** ☐ **$300,000**

Voluntary Accident Insurance Legally Domiciled Adults (LDA's) are not eligible for coverage. After-Tax deduction.

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

Coverage Type (choose one)
☐ **Employee Only** ☐ **Employee + Child(ren)** ☐ **Employee + Spouse** ☐ **Family Coverage**

Voluntary Critical Illness Insurance After-Tax deduction. Minimum Coverage $10,000 Maximum $20,000. Guarantee issue $20,000. Child Guaranteed issue is 25% of approved employee amount up to max of $5000.00

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

Coverage Type
☐ **Employee Amount Chosen $ _____** ☐ **Spouse Amount Chosen $ _____** ☐ **Child** ☐ **$2,500 or** ☐ **$5,000**

FLEXIBLE SPENDING ACCOUNTS (FSA) Only complete this form if you cannot enroll in a FSA account using the loyolaexpress.com portal.

Health Care Account –Election Max $2,600.00

Available to benefits eligible employees. Eligible expenses must be incurred between January 1st and December 31st or your date of eligibility as a new hire. 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, 2018 maximum $2,600.00) $ _____

Dependent Care Account –Election Max $5,000.00

Available to benefits eligible employees. Eligible expenses must be incurred between January 1st and December 31st or your date of eligibility as a new hire. 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. This account is not for healthcare related expenses for your dependents. 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, 2018 maximum $5,000.00) $ _____

Hyatt Legal

☐ **Enroll** ☐ **Waive**

DEPENDENT INFORMATION and Coverage Selections -Please use full legal name

Dependent's Last Name	Dependent's First Name	Middle	SSN or ITIN 000/00/0000	Relationship Spouse, LDA or Child	Date of Birth MM/DD/YR	Gender Male or Female

Medical Coverage	Dental Coverage	Vision Coverage	Child Life	Child Critical Illness	Spouse Life	Spouse Critical Illness
☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop

Medical Coverage	Dental Coverage	Vision Coverage	Child Life	Child Critical Illness	Spouse Life	Spouse Critical Illness
☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop

Medical Coverage	Dental Coverage	Vision Coverage	Child Life	Child Critical Illness	Spouse Life	Spouse Critical Illness
☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop

Medical Coverage	Dental Coverage	Vision Coverage	Child Life	Child Critical Illness	Spouse Life	Spouse Critical Illness
☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop

Medical Coverage	Dental Coverage	Vision Coverage	Child Life	Child Critical Illness	Spouse Life	Spouse Critical Illness
☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop

Medical Coverage	Dental Coverage	Vision Coverage	Child Life	Child Critical Illness	Spouse Life	Spouse Critical Illness
☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop

403B ENROLLMENT, TRANSIT ELECTIONS AND BENEFICIARY INFORMATION

403B Defined Contribution Retirement Program-Transamerica

If you wish to enroll in 403b program you can complete your enrollment by visiting our Loyola Transamerica Portal located on our Financial Wellness/ Retirement page at https://luc.edu/hr/benefits_retirement.shtml. Enrollment or changes to your 403b participation are not subject to New Hire, Qualifying Life Event or Annual Open Enrollment guidelines. The timing of 403b enrollment and changes can be impacted by payroll deadlines. You can also select your 403b beneficiaries via the Transamerica portal as well.

Transit Program

All eligible employees may elect transit via the Loyola Benefit Express website at www.loyolaexpress.com. Enrollment or changes to your transit participation are not subject to New Hire, Qualifying Life Event or Annual Open Enrollment guidelines. It takes 6-8 weeks for all changes to take effect.

Beneficiaries

All beneficiary changes are made online via Employee Self Service at https://lawson.luc.edu.

AUTHORIZATION, ACKNOWLEDGEMENT AND DECLARATIONS

Tobacco Premium

I understand that if I am found to be providing untruthful information on this certification, or if I fail to report a change in tobacco usage, it may result in disciplinary action leading up to and including termination of employment. Additionally, the consequences of a false statement, if discovered, are that you would lose all university contribution to your health premium.

Spouse/LDA Surcharge

I understand that if I am found to be providing untruthful information on this certification, or if I fail to report a change in my spouses/LDA's eligibility, it may result in disciplinary action leading up to and including termination of employment. Additionally, the consequences of a false statement, if discovered, are that you would lose all university contribution to your health premium.

Dependent Certification

By enrolling your Dependents you certify you understand the definition of a Dependent and acknowledge that misrepresentation by a Faculty and Staff member of benefit eligibility requirements constitutes a violation of Loyola University Chicago policy. All dependents must have documentation on file that that certifies their status as a legally eligible dependent. Dependent Children are allowed on the plan until the age of 26 unless they have been certified as disabled prior to the age of 26.

Payroll Deductions

After reviewing the insurance benefits and premiums of the plans, I wish to elect the indicated insurance coverage and authorize deductions or adjustments to my earnings for Coverage. All deductions related to Medical, Dental, Vision and Flexible Spending are pre-tax. All other deductions are after-tax unless otherwise noted in our Summary Plan Description.

I am authorizing Loyola University Chicago to take the required deductions from my pay for my benefit elections. 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:** __________

Please keep a copy of your completed form for your records.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 or supporting documentation via campus mail or US mail.

Email Form