



Benefit Enrollment Form 2021

New Enrollment and Life Event Changes

Personal Information- Please Print Clearly				
Employee Legal Last Name		Legal First Name		M.I.
<input type="checkbox"/> Male <input type="checkbox"/> Female Gender		Date of Birth m/d/yyyy		
Home Street Address			Apt/Unit	
City		State	Zip	
Work Email			<input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly Pay Frequency	
Hire Date	Home/Cell Phone	Work Number	Employee ID - HR Use Only	

TYPE OF ENROLLMENT:

- New Employee → Date of Hire: _____
- Annual Enrollment (coverage effective January 1st)
- Change in Status – Reason (select one): ↓
- Birth or Adoption Marriage Divorce
- Loss of Other Coverage
- Death of Covered Dependent
- Spouse Employment Loss
- Legal Guardianship
- Other: _____

Event Date: _____

NOTE: Request for coverage must be made **within 31 days** of qualified event. And documentation must support event.

Tobacco Use Certification Acknowledgement

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). For more details, please see the benefit booklet.

- 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- Only Complete this section if you are adding a Spouse/LDA to Medical Insurance

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. For more details, please see the benefit booklet.

- YES, my spouse/LDA is eligible for another employer's medical plan.
- 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)

Section 1 Medical Insurance Plans (Please Choose One Plan Only)

I want to Waive Health Insurance Coverage (skip to next section)

<input type="checkbox"/> PPO 1 <input type="checkbox"/> Enroll <input type="checkbox"/> Change Coverage <input type="checkbox"/> End Coverage	<input type="checkbox"/> Keep The Same (Only use if currently enrolled)	Select Coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Spouse/LDA <input type="checkbox"/> Family (Employee + Spouse/LDA + Child(ren))
<input type="checkbox"/> PPO 2 <input type="checkbox"/> Enroll <input type="checkbox"/> Change Coverage <input type="checkbox"/> End Coverage	<input type="checkbox"/> Keep The Same (Only use if currently enrolled)	
<input type="checkbox"/> PPO 3 HSA (If enrolling in PPO3, skip to Section 3) <input type="checkbox"/> Enroll <input type="checkbox"/> Change Coverage <input type="checkbox"/> End Coverage	<input type="checkbox"/> Keep The Same (Only use if currently enrolled)	

Section 2 PLEASE COMPLETE THIS SECTION ONLY IF ENROLLING IN PPO 1 OR PPO 2 MEDICAL INSURANCE PLAN

HEALTH CARE FLEXIBLE SPENDING ACCOUNT – Election Max \$2,750.00

- 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 annual enrollment.

Enroll Increase Decrease End FSA Account Waive Keep The Same (Only use if currently enrolled)

Annual Election Amount (minimum \$240.00, 2021 maximum \$2750.00) \$ _____

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT- Election Max \$5,000.00

- 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 AE 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.

Enroll Increase Decrease End Dependent FSA Account Waive Keep The Same (Only use if currently enrolled)

Annual Election Amount (minimum \$240.00, 2021 maximum \$5000.00) \$ _____

Section 3 PLEASE COMPLETE THIS SECTION ONLY IF ENROLLING IN PPO3 MEDICAL INSURANCE PLAN ONLY

HSA (Eligible faculty and staff who enroll in PPO3 HSA receive an HSA administered by BenefitWallet)

Enroll in Contributions Change Contribution Amount End Contributions Waive Contributions

Annual Election Amount **Individual** (2021 maximum \$3,600) \$ _____

Annual Election Amount **You + 1 or More** (2021 maximum \$7,200) \$ _____

- If you are age 55 or older, you can contribute an additional \$1,000 annually.
- You are not eligible for an HSA if you are enrolled in Medicare or claimed as a dependent on another person's tax return. Full-time or part-time employees who enroll in PPO3 HSA and are enrolled in Medicare or otherwise ineligible for an HSA will receive Loyola's contribution in an HRA account.

LIMITED FLEXIBLE SPENDING ACCOUNT (LFSA)

- **Applies only to dental and vision expenses, reimbursement for medical expenses are not allowed.** Election maximum is \$2,750.00.
- Eligible expenses must be incurred between January 1st and December 31st or your date of eligibility as a new hire. LFSA elections are not automatically renewed; elections expire December 31st of election year.
- **You must elect new FSA amounts for the following calendar year during annual 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.**

Enroll Increase Decrease End LFSA Account Waive **Keep The Same** (Only use if currently enrolled)

Annual Election Amount (minimum \$240.00, 2021 maximum \$2750.00) \$ _____

DEPENDENT CARE ACCOUNT- Election Max \$5,000.00

- 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 AE 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.**

Enroll Increase Decrease End Dependent FSA Account Waive **Keep The Same** (Only use if currently enrolled)

Annual Election Amount (minimum \$240.00, 2021 maximum \$5000.00) \$ _____

Section 4 Dental Insurance Plans (Please Choose One Plan Only)

I want to waive Dental Insurance Coverage (skip to next section)

Delta Dental (PPO)

Enroll Change Coverage End Coverage **Keep The Same** (Only use if currently enrolled)

Guardian 1st Commonwealth (DHMO) Chicagoland, Northern Illinois, NW Indiana Only

Enroll Change Coverage End Coverage **Keep The Same** (Only use if currently enrolled)

Select Coverage:

- Employee
- Employee + Child(ren)
- Employee + Spouse/LDA
- Family (Employee + Spouse/LDA + Child(ren))

Section 5 Vision Insurance Plan

I want to waive Vision Insurance Coverage (skip to next section)

Vision Service Providers (VSP) (PPO)

Enroll Change Coverage End Coverage **Keep The Same** (Only use if currently enrolled)

Select Coverage: Employee Only Employee + Child(ren) Employee + Spouse/LDA Family (Employee + Spouse/LDA + Child(ren))

Section 6 Voluntary Supplemental Life Insurance- Basic Life insurance coverage is provided at no cost to eligible faculty and staff at 1 1/2 times your salary not to exceed \$500,000.

Faculty and Staff, you may elect supplemental life insurance up to 5 times your annual salary or up to a maximum of \$500,000 and are subject to Evidence of Insurability (EOI). New hires or newly benefits eligible employees may elect up to \$250,000 without an EOI. An EOI is required if amount exceeds \$250,000. **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** 1 2 3 4 5 times my salary Keep the Same End Coverage Waive

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. **Any new election or increase to coverage made after your new hire enrollment period will require EOI. Reliance EOI Form**

Enroll Change Amount Keep the Same End Coverage Waive
 \$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

Section 6 (cont.) 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. Children over the age of 20 must be: unmarried, full-time college student, disabled and financial dependents of insured.

Enroll Change Amount Keep the Same End Coverage Waive

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

Enroll Change Amount Keep the Same End Coverage Waive

Coverage Type (choose one)

Employee OR Family

Coverage Amount (choose one)

\$50,000 \$100,000 \$200,000 \$300,000

Section 7 Voluntary Accident Insurance

- LDA's are not eligible for this plan.
- There is a wellness benefit included in this plan and you will be reimbursed up to \$75 for getting your annual physical each year.
- If you enroll in PPO3 HSA, you will automatically be enrolled for employee only accident coverage, paid for by Loyola. You have the option to purchase additional coverage for your spouse and/or dependent children.

Enroll Change Amount Keep the Same End Coverage Waive

Coverage Type (choose one)

Employee Employee + Child(ren) Employee + Spouse Family Coverage

Section 8 Voluntary Critical Illness Insurance

- LDA's are not eligible for this plan.
- Child Guaranteed issue is 25% of approved employee amount up to max of \$5,000.00.
- There is a wellness benefit included in this plan and you will be reimbursed \$50 for getting your annual physical each year.
- If you enroll in PPO3 HSA, you will automatically be enrolled for employee only \$10,000 Critical Illness benefit, paid for by Loyola. You have the option to purchase additional coverage for your spouse and/or dependent children.

Enroll Change Amount Keep the Same End Coverage Waive

Coverage Type (choose one coverage level and one amount)

Employee \$10,000 or \$20,000
 Spouse \$10,000 or \$20,000
 Child \$2,500 or \$5,000

Section 9 MetLife Legal

Enroll Waive

Section 10 Dependents-Please add your dependents information and select the insurance coverage needed.

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 <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Vision Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Child Life <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Child Critical Illness <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Spouse Life <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Spouse Critical Illness <input type="checkbox"/> Enroll <input type="checkbox"/> Drop
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Vision Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Child Life <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Child Critical Illness <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Spouse Life <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Spouse Critical Illness <input type="checkbox"/> Enroll <input type="checkbox"/> Drop
Medical Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Dental Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Vision Coverage <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Child Life <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Child Critical Illness <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Spouse Life <input type="checkbox"/> Enroll <input type="checkbox"/> Drop	Spouse Critical Illness <input type="checkbox"/> Enroll <input type="checkbox"/> Drop
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403(b) Enrollment, Transit Elections and Beneficiary Information

403(b) Defined Contribution Retirement Program-Transamerica

The 403(b) plan has an automatic enrollment feature. After 60 days of employment, the University will automatically enroll employees in the plan at 1% of salary and your contributions will be allocated to the plan's "default" investment option. Employees may elect to opt out of this feature, change their investment elections or increase their payroll contributions by contacting Transamerica at 773.508.2770 or visiting luc.trsrretire.com. The timing of 403(b) contribution 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 can be made at any time. It takes 6-8 weeks for all changes to take effect.

Beneficiaries

All Life Insurance beneficiary elections are made online via Employee Self Service at <https://ess.luc.edu/>.

AUTHORIZATION, ACKNOWLEDGEMENT AND DECLARATIONS

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 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. Save completed form then scan/email and send via **secured email** to Benefits@luc.edu. You may refer to the Loyola Benefits Handbook and plan guides for details at <https://www.luc.edu/hr/benefits.shtml>
Please do not send this form or supporting documentation via campus mail or US mail.

Human Resources | Loyola University Chicago

Email: Benefits@luc.edu

Fax: 312.915.7612