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

Legally Domiciled Adult (LDA) Certification Form

Benefit Eligible Faculty and Staff Only

To enroll a legally domiciled adult (LDA) in a Health, Dental and/or Vision Plan or utilize the Dependent Tuition Benefit program please complete all six sections of this form. Once the form is completed, please make a copy for your records and submit via fax or email to as soon as possible to:
Human Resources Department
ATTN: Benefits at benefits@luc.edu

1. EMPLOYEE INFORMATION PLEASE PRINT CLEARLY

Employee Last Name	First Name	M.I.	Social Security Number (last four digits)

Home Street Address	Apt/Unit	City	State	Zip

Home Phone	Work Extension	Work Email	Employee ID

2. LDA INFORMATION *only complete the following section with the LDA information.* Also check the enroll box next to each benefit you wish your LDA to have

Full Legal Last Name	Full Legal First Name	MI	Gender	Date of Birth	Social Security Number/ITIN
			☐ Male ☐ Female	/ /	- -

Relationship to Employee:	Medical Coverage	Dental Coverage	Vision Coverage	Tuition Benefit (undergrad only & Taxable)
	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive

Please note: Selecting benefit coverage levels does not guarantee coverage or approval of LDA Certification Application.

3. LEGAL DOMICILED ADULT ELIGIBILITY AFFIRMATION-PLEASE COMPLETE EITHER CATERGORY (A) or CATERGORY (B)

By electing legally domiciled adult health care, dental and/or vision coverage, I certify that all the following eligibility criteria have been met. Please complete the questions listed under Section A or Section B. If your LDA does not meet ALL of the criteria for either category (A) or category (B) they will NOT be eligible for Legally Domiciled Adult coverage under Loyola University Chicago Benefits.

A: The individual for whom I am applying for coverage satisfies the following requirements:

	Please Check Yes OR No
Is 18 or older and will be Medicare eligible;	☐ Yes ☐ No
Has lived with the employee for at least six months and intend to remain a member of the household during the period of coverage;	☐ Yes ☐ No
Has a close personal relationship with the employee;	☐ Yes ☐ No
Shares basic living expenses and be financially interdependent with the employee;	☐ Yes ☐ No
Is not related to the employee by blood in any way that would prohibit legal marriage;	☐ Yes ☐ No
Is not legally married to anyone else;	☐ Yes ☐ No
Is not receiving benefits from any employer nor be eligible for any group Coverage	☐ Yes ☐ No
Is an US Citizen	☐ Yes ☐ No
Is not receiving benefits from any employer nor be eligible for any group	☐ Yes ☐ No

OR

B: The individual for whom I am applying for coverage is a Qualified Tax Dependent that satisfies the following requirements:

	Please Check Yes OR No
Is 18 or older and will be Medicare eligible;	☐ Yes ☐ No
Is a blood relative of the employee	☐ Yes ☐ No
Meets the definition of dependent under Internal Revenue Code Section 152 during the period of coverage	☐ Yes ☐ No
Has lived with the employee for at least six months and intend to remain a member of his/her household during the period of coverage	☐ Yes ☐ No
Is neither receiving benefits from an employer nor be eligible for any group coverage.	☐ Yes ☐ No
Is an US Citizen	☐ Yes ☐ No

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Benefit Eligible Faculty and Staff Only

4. LEGAL DOMICILED ADULT ELECTION AND TAX TREATMENT

I, _____ certify the following: (Employee must check one of the options below)
Employee First and Last Name-Please Print Clearly

☐ **In category (A)** I hereby certify that the named legally domiciled adult (LDA) whom I am enrolling for medical, dental and/or vision coverage **does not** qualify as my legal tax dependent under Section 152 of the Internal Revenue Code. I understand that the value of the coverage received by my Legally Domiciled Adult (LDA) less any contributions paid by me for such coverage **will** be treated as taxable income to me and that my contributions toward this coverage must also be paid on an after-tax basis.

☐ **In category (B)** hereby certify that the named legally domiciled adult (LDA) whom I am enrolling for medical, dental and/or vision coverage **does** qualify as my legal tax dependent under Section 152 of the Internal Revenue Code. I understand the value of the coverage received by my legally domiciled adult (LDA) **will not** be treated as taxable income to me and that my contributions toward this coverage will be paid on a pre-tax basis.

5. SUPPORTNG DOCUMENTATION NEEDED-Joint documents must be dated a minimum of 6 months prior to enrollment effective date. Please provide 2 of the documents listed below.

☐ Copy of the prior year jointly filed Federal tax return (REDACT PERSONAL FINANCIAL INFORMATION)
☐ Proof of joint ownership of property (joint mortgage deed or apartment lease)
☐ Civil Union Certificate
☐ Joint bank account or credit accounts
☐ Copies of Joint Utility Statements
☐ Copy of prior year's federal tax return (form 1040) confirming the LDA is a qualified tax dependent as defined in Section 152 of Internal Revenue code. **–CATEGORY (B) ONLY.**

6. LDA HEALTH INSURANCE SURCHARGE WAIVER ELIGIBILITY

If your LDA is unemployed, self-employed, works part-time, works at Loyola or works full-time but is not eligible for health insurance coverage they may meet eligibility requirements for the surcharge waiver which can result in reduced premiums health insurance rates. If so you MUST complete the surcharge form in order to receive the reduce premium rate. If your LDA does NOT meet requirements no additional form is needed.

Does your LDA Meet Health Insurance Surcharge Waiver Requirements?

☐ **YES -Please complete surcharge waiver form in addition to this form. The LDA Surcharge Waiver Forms are located here.**

☐ **NO - My LDA does not meet Health Insurance surcharge waiver qualifications**

7. LEGAL DOMICILED AFFIRMATION

- I have read terms and conditions for enrolling a Legally Domiciled Adult Health, Dental and/or Vision Benefits.
- I certify that the information provided in all parts of this form is true, accurate and complete.
- I understand that if any of the information is not true and correct, Loyola University Chicago reserves the right to take disciplinary action, up to and including termination.
- I agree to notify Loyola University Chicago if LDA eligibility ends.
- I have been advised that I should consult a tax professional for advice about the potential tax implications of electing LDA coverage**.**
- I understand that if I elect coverage for a legally domiciled adult who is not my federal tax dependent, the Internal Revenue Code requires: 1) Loyola University Chicago to treat the full fair market value of the benefits for a LDA as taxable income and 2) prohibits reimbursement of the LDA's expenses through a Health Care Reimbursement Account.
- I understand that Loyola University Chicago has the right to discontinue coverage at any time, and will extend COBRA coverage to an LDA.
- I must contact the Human Resources Benefits Department immediately should my LDA's eligibility status change.

Signature of Employee:	**Date:**
Signature of Legally Domiciled Adult (LDA):	**Date:**

Please fax completed forms to: 312-915-7612 or scan and email to benefits@luc.edu. Do not send forms via US Mail or Campus Mail.