Preparing People to Lead Extraordinary Lives
LOYOLA UNIVERSITY CHICAGO

Benefits Selection Form-SSOM

Last Name:	First Name:	Social Security #: (Last 4-digits)
Home Address:	City/State/Zip	Marital Status: Single ☐ Married ☐
		Date of Birth:
Home phone:	Work phone:	
Hire Date:	Faculty: ☐ Staff ☐ Full time ☐ Part time ☐	ID #
Department:	Male ☐ Female ☐	

1. Health Plan Options – PPO and HMO Plans (choose one)

BC/BS Option I PPO ☐
BC/BS LU Preferred PPO ☐
HMO Illinois ☐

Coverage level for health
Single ☐ Family ☐
Single+Child(ren) ☐ Single+LDA ☐
Single+Spouse ☐ Single+LDA+Child(ren) ☐
NO Coverage ☐

Employer Only
Group:
Section:
Effective date:

2. Dental Plan Options (choose one)

Delta Dental PPO ☐
Guardian/First Commonwealth DHMO ☐
Include dentist code:

Coverage level for dental
Single ☐ Family ☐
Single+Child(ren) ☐ Single+LDA ☐
Single+Spouse ☐ Single+LDA+Child(ren) ☐
NO Coverage ☐

Employer Only
Group:
Section:
Effective date:

3. Employee/Dependent Required Information

Name: (Last, First, M.I.)	Social Security Number	DOB M/D/Y	M/F	If enrolling in HMO, Provide name/ Primary Care Physician (PCP)#	Group/IPA #
Employee:					
Spouse/LDA:					
Child:					
Child:					
Child:					
Child:					

4. Are you or your family members covered by another group health insurance plan? Yes ☐ No ☐ If yes, please provide:
Policy #: ID #:
Name of insured person:
Employed by:

5. Are you or your family members covered by Medicare?
Yes ☐ No ☐
Name of Medicare enrollee:
HIC# Start date:

STOP 6. Flexible Spending Account

Enrollment in FSA accounts is directly through Benefit Express See On-line benefits booklet for details. To enroll go to **www.loyolaexpress.com**. ***Remember, enrollment in FSA accounts must be done annually.***

STOP 7. Long Term Care-CNA Insurance

Enrollment in long term care benefits is directly through CNA Insurance. See On-line benefits booklet for details. To enroll go to **www.ltcbenefits.com**

8. Vision Plan Options

Vision Service Plan ☐
Always Vision ☐

Coverage level for vision
Single ☐ Single+Spouse ☐ Single+Child(ren) ☐ Family ☐
Single+LDA ☐ Single+LDA+Child(ren) ☐ No coverage ☐

Hyatt Legal Services
Yes ☐ No coverage ☐

9. Life Insurance

Employer only: Grp: Sec: Amt:
Total amount:

Supplemental Life
Yes ☐ No coverage ☐
Select in increments of your salary.
1x salary ☐
2x salary ☐
3x salary ☐
4x salary ☐
5x salary ☐
Your selection may be subject to Evidence of Insurability provisions. Please see On-line Benefits Booklet for more information

Dependent Life Spouse Yes ☐ No Coverage ☐

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

Dependent Life Child(ren)
Flat $5,000 coverage
Yes ☐
No Coverage ☐

Accidental Death and Dismemberment
Level of coverage:
Employee ☐ Employee+Family ☐ No Coverage ☐
Coverage Amounts:
$50,000 ☐ $100,000 ☐ $200,000 ☐ $300,000 ☐

10. Beneficiary Designation (provide name of individual and relationship to you)

Primary:
Secondary:

11. Qualifying Life Event Changes

Reason for Event Change (select below):
New Hire ☐ Marriage ☐
Birth or Adoption ☐
Divorce ☐ Loss of Prior Insurance Coverage ☐
Name Change ☐ – List prior name:

Date of Event Change: _____

To add or remove any dependent(s) complete Section 3 for those dependent(s) change(s) only

Mail completed forms to: Loyola University Health Systems- Human Resources - Medical Center, 2160 S. First Avenue, Maywood, IL 60153, or via enter-campus mail to Human Resources-Benefits Dept., Mulcahy Bldg. 106, Room 1605, LUMC

I apply for the coverage indicated and authorize Loyola University Chicago to deduct the cost of my selected coverage from my pay. My health and dental contribution will be reduced in pre-tax dollars unless otherwise indicated in writing to Human Resources Dept. I understand that benefits are available subject to terms and conditions specified in the benefit description. Upon presentation of the original or copy of this form, I authorize any medical professional, hospital, clinic or other medically related facility, government agency or other person or firm to provide information (including copies of records) concerning advice, care or treatment provided to me and/or my covered dependents including without limitation, information related to mental illness, use of drugs or alcohol, to the authorized representatives involved in evaluating, determining or administering claims for insurance benefits for me and my covered dependents. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed through the terms and conditions of the policy. Additionally, I certify that all of the information which I have submitted is accurate to the best of my knowledge. Failure to provide accurate information may result in suspension of benefit eligiblity.

Signature of Employee_____ **Date**_____