

Loyola College in Maryland
FY09 Benefits Enrollment Form
 Enrollment Period Effective July 1, 2008 – June 30, 2009

New Hire New Enrollment Qualified Life Event Change Name/Address Change Add/Drop Coverage Rehire

Employee Name: (Last, First, Middle Initial) _____ Social Security Number: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Male Female Date of Birth: (Month / Date / Year) _____ Marital Status: Single Married Divorced

Salary: \$ _____ Occupation: _____ Date of Hire: ____/____/____ Effective Date of Enrollment: ____/____/____

Dependents: Please list spouse and all children in your family below.

Relationship:	Add Or Drop	Dependent Name: (Last, First, Middle Initial)	Date of Birth:	Gender: Male Female	Social Security Number:	Full Time Student over Age 19: Y or N	Name of College:	Is Child Totally Disabled: Y or N
Spouse								
Child								
Child								
Child								
Child								

COVERAGE SECTION: (must be completed)

Waiver of Medical Insurance: In waiving medical insurance, I certify I have medical insurance under another plan and do not wish to elect medical insurance through Loyola College.

Medical Options:
 Carefirst BlueCross BlueShield PPO
 BlueChoice HMO (All members enrolled must select a participating Primary Care Physician)
 Coverage for: Employee Two Party Family (If more than Employee to be covered list dependents to be enrolled. Additional dependents can be listed on a separate page.)
 Names: 1) _____ 2) _____ 3) _____ 4) _____
 PCP: 1) _____ 2) _____ 3) _____ 4) _____

Coordination of Benefits: Do you or your dependents have any other health insurance policy other than through your employer?
 Yes No

Dental Options:
 Metlife Dental PPO Plan Metlife Dental Copay Plan Waive Dental Coverage
 Coverage for: Employee Two Party Family (If more than Employee to be covered list dependents to be enrolled. Additional dependents can be listed on a separate page.)
 Names: 1) _____ 2) _____ 3) _____ 4) _____

Vision Options:
 VSP Buy- Up Waive Vision Buy-Up Coverage
 Coverage for: Employee Two Party Family (If more than Employee to be covered list dependents to be enrolled. Additional dependents can be listed on a separate page.)
 Names: 1) _____ 2) _____ 3) _____ 4) _____

Short-Term Disability: Short-Term Disability Waive Short-Term Disability

Life Insurance: Supplemental Life Insurance Waive Supplemental Life Insurance
 (check coverage amount: \$25,000 \$50,000 \$100,000 \$150,000)

Beneficiary Designation: Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.

Life Insurance Beneficiary Designation:	First Name	Last Name	Date of Birth	Relationship	Telephone Number/Contact Information	Benefit %
Primary						
Primary						
Contingent						
Contingent						

Dependent Life Insurance: Dependent Life Insurance \$10,000.00 Spouse / \$5,000.00 Child(ren) Waive Dependent Life Insurance

Flexible Spending Accounts:
 Health Care Flexible Spending Account (annual maximum \$5,000) \$ _____
 Dependent Care Flexible Spending Account (annual maximum \$5,000) \$ _____
 Waive Flexible Spending Accounts

Signature required on reverse side.

I understand that by signing and submitting this Benefits Enrollment Form, I am making a binding election for the plan year. Loyola College reserves the right, in its sole discretion, at any time, to amend this plan in whole, or in part, or to terminate the plan at any time with advance notice pursuant to the terms of the plan documents.

Employee Signature _____

Date _____

FY09 Annual Premiums

Medical Options - Annual Cost

	Employee	Two Party	Family
Carefirst BlueCross BlueShield PPO	\$ 1,209.00	\$ 4,788.29	\$ 7,182.58
BlueChoice HMO	\$ 1,157.98	\$ 4,640.40	\$ 6,606.96

Dental - Annual Cost

	Employee	Two Party	Family
MetLife PPO Plan	\$ 315.07	\$ 631.17	\$ 1,095.32
MetLife Copay Plan	\$ 218.04	\$ 457.32	\$ 821.76

Vision - Annual Cost

	Employee	Two Party	Family
VSP Buy-UP	\$ 88.68	\$ 134.16	\$ 252.36

Life Insurance - Supplemental life insurance elections are based on your age as of July 1, 2008.

Age	29 or under	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54
<input type="checkbox"/> \$25,000	13.20	19.80	26.40	29.70	45.00	69.00
<input type="checkbox"/> \$50,000	26.40	39.60	52.80	59.40	90.00	138.00
<input type="checkbox"/> \$100,000	52.80	79.20	105.60	118.80	180.00	276.00
<input type="checkbox"/> \$150,000	79.20	118.80	158.40	178.20	270.00	414.00
Age	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 or older
<input type="checkbox"/> \$25,000	129.00	184.80	353.10	570.90	570.90	570.90
<input type="checkbox"/> \$50,000	258.00	369.60	706.20	1,141.80	1,141.80	1,141.80
<input type="checkbox"/> \$100,000	516.00	739.20	1,412.40	2,283.60	2,283.60	2,283.60
<input type="checkbox"/> \$150,000	774.00	1,108.80	2,118.60	3,425.40	3,425.40	3,425.40

Current employees must provide medical approval when electing any level of optional life as a new or increased benefit. A Statement of Health must be completed and submitted to Human Resources.

Dependent Life Insurance

\$10,000.00 Spouse / \$5,000.00 Child(ren)

Employee's Annual Premium : \$28.80

Short-Term Disability – Premiums are based on your salary as of July 1, 2008

Use this calculation if you **are** receiving Loyola's Retirement Plan Contribution.

Base Wage	Divide by	Multiply by	Annual Cost
\$	100	0.234	\$

Use this calculation if you **are not** receiving Loyola's Retirement Plan Contribution.

Base Wage	Divide by	Multiply by	Annual Cost
\$	100	0.190	\$

Current employees must provide medical approval when electing short-term disability as a new benefit. A Statement of Health must be completed and submitted to Human Resources.

Flexible Spending Accounts (you must make a new election each benefit year)

Health Care Flexible Spending Account (annual maximum \$5,000.00)

Dependent Care Flexible Spending Account (annual maximum \$5,000.00)