



2008 Medical Insurance Election Form

Please print all necessary information

New Enrollment

Change in Plan Options Change in Coverage Category (Change of Status)
 BCBS Subscriber ID # _____

1. Employee Information

| | | | | | | |
|----------------|------------|-------|---------------|-------------------|-----------------------------------------------------------------|-----------|
| Last Name | First Name | M.I. | Date of Birth | Social Security # | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Hire Date |
| Street Address | City | State | Zip Code | Home Phone | Work Ext. | |

2. Medical Coverage

Plan Options:

| | | | |
|--------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Blue Cross Point of Service CORE Plan #50 | <input type="checkbox"/> Blue Cross Point of Service BASIC Plan #46 | <input type="checkbox"/> Blue Cross Point of Service PLUS Plan #42 | <input type="checkbox"/> Waiver of Benefits |
|--------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------|

Coverage Category: (Change in Status)

| | | | |
|----------------------------------------|----------------------------------------------|--------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Yourself Only | <input type="checkbox"/> You and Your Spouse | <input type="checkbox"/> You and Your Child(ren) | <input type="checkbox"/> You, Your Spouse and Your Child(ren) |
|----------------------------------------|----------------------------------------------|--------------------------------------------------|---------------------------------------------------------------|

- ❖ If you are currently enrolled in one of the Blue Cross Point of Service (POS) plans and you wish to change your plan election, you **MUST** complete this Election Form. However, you are **NOT** required to complete the separate Blue Cross Enrollment Change Form for Coverage.
- ❖ If you are currently enrolled in one of the Blue Cross Point of Service (POS) plans but you wish to make a change in your Coverage Category, you **MUST** complete this Election Form and the Blue Cross Enrollment Change Form. [i.e., add/delete spouse and/or dependent(s)]
- ❖ If you are not currently enrolled in a Loyola sponsored medical option and wish to elect medical coverage for 2008, you **MUST** complete this Election Form and the Blue Cross Enrollment Change Form.
- ❖ If you wish to waive medical coverage, you **MUST** complete this Election Form and select the “Waiver of Benefit” option.

2. Employee Signature

I hereby enroll for the medical plan option indicated on this form and for which I am eligible or may become eligible under the provisions of the plans. I authorize my employer to deduct from my earnings my contributions for coverage, and I understand that contributions will be made on a before-tax basis, as allowed by law. I understand the election I have made will become effective January 1, 2008 or the first of the month on or after the date of hire whichever is later. Any choices I have made above may only be altered as the result of a change in family status or open enrollment period as defined in the summary plan.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. All references to Blue Cross include HMO Louisiana.

Signature _____ Date _____

**RETURN YOUR COMPLETED FORM TO THE LOYOLA BENEFITS DEPARTMENT-BOX #16
 FAX NUMBER: 504-864-7100**