

Check the appropriate box.
If you are a current BCBS member include your subscriber ID # from your ID card.



2010 Medical Insurance Election Form

Please print all necessary information

New Enrollment

Change in Plan Options **Change in Status (Coverage Category)**
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:

Check the appropriate box

- Blue Cross Point of Service CORE Plan #61
 Blue Cross Point of Service BASIC Plan #57
 Blue Cross Point of Service PLUS Plan #53
 Waiver of Benefits

Coverage Category:

Check the appropriate box

- Yourself Only
 You and Your Spouse
 You and Your Child(ren)
 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 2009, 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, 2010 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