LOYOLA UNIVERSITY CHICAGO RETIREE HEALTH REIMBURSEMENT ACCOUNT FORM

LAST NAME:	FIRST NAME:	MI:

Employee ID #:	ADJUSTED HIRE DATE:	RETIREMENT DATE:

BIRTH DATE:	PHONE #:

PERMANENT RESIDENCE STREET ADDRESS:

CITY:	STATE:	ZIP CODE:

RETIREE HEALTH FUNDING OPTION

☐ I elect a Retiree Health Reimbursement Account that I may use to receive reimbursement for eligible healthcare expenses. I understand I may reduce my account balance for any qualified medical expenses including; Medicare/Medigap premiums, a spouse's plan, or any other health care coverage. When the account is depleted. I am responsible for paying 100% of any future healthcare costs. The current value of my Retiree Health Account is: $ ____________________

SURVIVING SPOUSE DESIGNATION

I understand that upon my death, my spouse is entitled to the Health Reimbursement Account as long as my spouse does not re-marry. My surviving spouse designation is as follows:

Spouse's Name: ____

Spouse's Social Security Number: ____

Spouse's Date of Birth: ____

SIGNATURE

By signing below, I understand that my Retiree Health funding election is an irrevocable election, which means that I cannot change it in future years.

______________________________________ RETIREE SIGNATURE

____________________ DATE