Concordia Plan Services
The Lutheran Church—Missouri Synod
PO Box 229007
St. Louis, MO 63122-9007

CONCORDIA PLANS

Toll Free: 888-927-7526
St. Louis: 314-965-7580
Fax: 314-996-1127
E-mail: info@ConcordiaPlans.org
Website: ConcordiaPlans.org

Seminary Student
Open Enrollment Application

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

A Seminary Information

Please check one.

☐ Concordia Seminary
801 Seminary Place
St. Louis, MO 63105
Phone: 314-505-7000
Account SEMSL

☒ Concordia Theological Seminary
6600 North Clinton St.
Fort Wayne, IN 46825
Phone: 260-452-2100
Account SEMFW

B Student Information

Full Name (Last, First, Middle Initial) ____ Previous Last Name ____ Social Security Number ____

Home Address ____ City ____ State ____ Zip Code ____

E-mail Address ____ Daytime Phone Number ____

C Concordia Health Plan Coverage Level

Please check your desired level of coverage from the following:

☐ Self Only (Class 1) ☐ Self and Spouse (Class 2) ☐ Self and Child(ren) (Class 3) ☐ Self, Spouse, and Child(ren) (Class 4)

I understand that coverage will be effective on September 1, 2019. **Please initial here:** ________________

D Dependent Information

If you are adding a spouse or child, complete this section. To enroll your child(ren), review 1 and 2 below to determine dependent eligibility for the CHP. You may be required to submit a birth certificate or other legal documentation. If your spouse is on active duty in any military force of any country, your spouse is not eligible to be enrolled as a dependent.

1. Your child, up to age 26, regardless of student, employment, marital or disabled status
2. Your unmarried totally disabled child who became disabled before attaining age 26 (subject to approval)

THE FOLLOWING DEPENDENT(S) IS/ARE TO BE ENROLLED IN THE CHP:

- *If listing more dependents than space provided, attach sheet giving information as requested below.*
- *If adding a newborn, do not wait for a Social Security number (SSN) to be issued to add the child. Once the newborn's SSN is issued, submit it to Concordia Plan Services.*

Dependent's Full Name	Relationship	Date of Birth	Social Security Number

(Continued on reverse side)

E Student Signature

I verify that the information entered on this form is current and correct to the best of my knowledge. I understand that if I have elected coverage, the cost of participation is my responsibility, according to the provisions of the Concordia Health Plan. Furthermore, I understand that the Seminary will collect the cost of the health coverage from me and remit the amount due to Concordia Plan Services on my behalf. I agree to provide legal documentation of any dependent's relationship to me upon request. I agree to notify Concordia Plan Services immediately of any changes in dependent eligibility status in the future.

X

Signature of Seminary Student   Date

F Seminary Representative Signature

I verify that the information entered on this form is current and correct to the best of our knowledge. If the student has elected coverage, the Seminary agrees to obtain from him or her, the cost for participation required according to the provisions of the Concordia Health Plan, and to remit the amount due directly to Concordia Plan Services.

X

Signature of Authorized Seminary Representative   Date

Printed Name of Authorized Seminary Representative   Title or Office Held

E-mail Address   Daytime Telephone Number

Please complete and submit this form to Concordia Plan Services by September 13, 2019.

Mail or fax this form to Concordia Plan Services
P.O. Box 229007 ● St. Louis, MO 63122-9007 ● Fax 314-996-1127

Missing information will delay the processing of the application or may result in the application being denied.