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

CONCORDIA PLANS

Request For Membership Change

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

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

Member Section

A Member Information

Title | Last Name | First Name | Middle Initial | Suffix | Previous Last Name

Address | City | State | Zip Code

Social Security Number | Date of Birth (MM/DD/YYYY) | Sex (M/F) | Marital Status | Marital Status Date (MM/DD/YYYY)

Preferred Phone Number | Preferred Email Address | Country in Which You Hold Citizenship

B Minister of Religion

Will your name appear on the Synod's Roster of Ordained and Commissioned Ministers of Religion? ☐ Yes ☐ No
Will you be participating in Social Security?..... ☐ Yes ☐ No

☐ As a minister of religion enrolled in the CRP prior to 1982 with participation terminated for no more than 5 years since, and whose self-employed status under Social Security has been in effect since December 31, 1981, I request enrollment in the CRP Traditional Option on the Full Basis.

C

Please list your dependents, including your spouse. If listing more dependents than the space provided, attach a sheet giving information as requested below.

Dependent's Full Name (Last - if different than yours, First, Middle Initial)	**Relationship**	**Sex** (M/F)	**Date of Birth** (MM/DD/YYYY)	**Social Security Number**	**Enroll in** CHP | CDSP
					☐ | ☐
					☐ | ☐
					☐ | ☐
					☐ | ☐

Dependent eligibility requirements are different for the CHP and CDSP. More detailed information is available at ***ConcordiaPlans.org*** or by calling Concordia Plan Services at 888-927-7526. Proof of eligibility may be required before payment of claims from the CDSP.

D

If your employer has adopted the Concordia Health Plan (CHP) and you meet the eligibility requirements, you may enroll yourself and your eligible dependents by choosing a class of coverage and a plan option below. Please contact your employer for information regarding any cost you may incur. **You can *only* elect an option being offered by your employer.**

Check one Class of Coverage

☐ Self Only ☐ Self and Spouse ☐ Self and Children ☐ Self, Spouse, and Children

☐ I am not enrolling in CHP (Please complete section F and see terms of special enrollment)

Bundled Plans: *The plans below include dental and vision coverage. You will be enrolled in the same class of coverage for health, dental and vision.*

☐ Option A ☐ Option B ☐ Option C ☐ Option D ☐ Option E ☐ Option HDHP ☐ Select 500 ☐ Select 1000
☐ Choice 1500 ☐ Choice 2000 ☐ Choice 3000 ☐ Option HMO ☐ Option HMO-C ☐ Option HMO-C2

Un-Bundled Plans: *If you choose one of these plans, you must also select a class and plan from the dental and vision options listed below.*

Medical

☐ Healthy Me A ☐ Healthy Me B ☐ Healthy Me C ☐ Whole Health ☐ Whole Health 1000 ☐ Whole Health 2000

Dental

☐ Self Only ☐ Self and Spouse ☐ Self and Children ☐ Self, Spouse, and Children ☐ Waive Dental Coverage

☐ Dental A ☐ Dental B ☐ Dental HMO

Vision

☐ Self Only ☐ Self and Spouse ☐ Self and Children ☐ Self, Spouse, and Children ☐ Waive Vision Coverage

☐ Vision A ☐ Vision B

(Continued on next page)

E Reason for Non-Enrollment in the Concordia Health Plan

Check the box next to the reason you are declining CHP coverage.

- ☐ I am covered under my spouse's or parent's group health plan (coverage by virtue of employment, including military service).
- ☐ I am covered as a dependent under my spouse who is also enrolled in CHP as a worker.
- ☐ I am covered under a military plan (TRICARE) as a retiree, a state mandated plan (e.g., Hawaii), a Medicare Supplemental plan or other government plan (e.g., Medicaid), or another country's mandatory health plan while residing outside the United States.
- ☐ I am covered under the health plan of a non-LCMS employer for whom I am currently working, a former employer's health plan or COBRA coverage.
- ☐ I have purchased coverage through the Health Insurance Marketplace made available by the Affordable Care Act and was eligible for a Premium Tax Credit at the time such coverage was purchased.
- ☐ I am not eligible for enrollment at this time due to the number of hours worked.
- ☐ I am not enrolling for some other reason _____

F Request to Terminate Coverage

Members may terminate CHP coverage at the end of any month by submitting your request within 30 days of the desired effective date, otherwise coverage will terminate at the end of the month in which CPS receives the written request to terminate coverage.

Please terminate my CHP participation effective _____. *(Complete Section E.)*

If listing more dependents than space provided, attach sheet giving information as requested below.

Reasons for Termination: 1. Active Military Duty 2. Has Full-Time Employment 3. Marriage 4. Other

Name of Dependent	Relationship	Reason for Termination *(Please check one)*	Remove From:		Date Event Occured (MM/DD/YYYY)
			CHP	CDSP	
		☐ 1 ☐ 2 ☐ 3 ☐ 4 _____	☐	☐	
		☐ 1 ☐ 2 ☐ 3 ☐ 4 _____	☐	☐	
		☐ 1 ☐ 2 ☐ 3 ☐ 4 _____	☐	☐	

G Supplemental Life and Accidental Death and Dismemberment

All full time workers are eligible to enroll in Supplemental Life or Accidental Death and Dismemberment (AD&D) for themselves and qualified dependents if their employer is participating in any of the Concordia Plans and agrees to remit payments. Eligibility requirements for children in both of these coverages follow the same guidelines of the Concordia Disability and Survivor Plan (CDSP). Once you receive a benefit confirmation from Concordia Plans, you may enroll in either or both of these additional plan options. To access more information and application forms, visit www.concordiaplans.org/life-loss or contact Concordia Plans at 888-927-7526.

H Worker Signature

The information entered on this form is current and correct to the best of my knowledge.

X _____

Signature of Worker Date (MM/DD/YYYY)

To be Completed by Employer Representative:

I Employer Information

_____

Employer Name Employer ID Number

_____

Address City State Zip Code

(Continued on next page)

J Changes to Worker Duties, Hours, Employment Classification Affecting Compensation

Change Request Information					1	2	3	4	5
Change Request	No Change	Effective Date Month	Day	Year	Basic Annual Cash Salary	Calculate 25% Home Provided (25% of Column 1)	Annual Cash Housing Allowance Paid to Worker	Cash Utility Allowance Paid to Worker	Total Salary (Sum of Columns 1, 2, 3, 4)
Salary	☐								
Duties/Job Title	☐				Duties/Job Title:				
Hours	☐				Hours Worked per Week Changed to:				
Employment Classification	☐				Employment Classification *(Check all that apply)* ☐ LCMS Rostered ☐ Non-Rostered ☐ Hourly ☐ Salaried				

K Employer Representative Signature

The information entered on this form is current and correct to the best of our knowledge. We agree to obtain from the worker, any portion of the cost for participation required from the worker according to the provisions of the Concordia Plans, and to remit such portion along with the portion required by us as the worker's employer.

X _____

Signature of Authorized Employer Representative — Date (MM/DD/YYYY)

Printed Name of Authorized Employer Representative — Title or Office Held

Email Address — Daytime Phone Number

Terms of Special Enrollment

You and/or your eligible dependents may be able to enroll in the Concordia Health Plan at a later date under the special enrollment provisions if you decline CHP coverage due to coverage in another health plan.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the CHP if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must request enrollment **as soon as possible but no later than 60 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment in writing **within 60 days** after the marriage, birth, adoption, or placement for adoption. Failure to enroll within the 60-day period may result in enrollment being delayed until the next open enrollment period.

To request special enrollment or obtain more information, contact Concordia Plan Services Customer Care Team at 888-927-7526.

Please retain this sheet for your records.