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

CONCORDIA PLANS

Enrollment Form

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

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

Member Section

A Worker 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 Dependent Information

Please list all your dependents below and select the boxes to indicate their enrollment in the medical, dental, and/or vision plan options elected in Section C. If listing more dependents than space provided, attach a sheet providing information as requested below.

If you are married or have children, please list them as dependents, regardless of your enrollment in the CHP.

If you have enrolled in a Bundled CHP Option, you only need to check the Medical box for those dependents you wish to enroll. They will automatically be enrolled with dental and vision coverage.

If you have enrolled in an Unbundled CHP Medical, Dental, and/or vision option(s), you need to check all the plans that you wish each dependent to be enrolled in. You can elect different plan enrollments for each dependent.

Dependent's Full Name	Relationship	Gender	Date of Birth	Social Security Number	Enroll In: Medical	Dental	Vision
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

C Concordia Health Plan

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 plan Option and Class of Coverage below and completing Section E. Please contact your employer for information regarding any cost you may incur. You can only elect an Option being offered by your employer.

If you are declining to enroll in the CHP, please check the box below and complete Section D.

☐ I decline enrollment in the CHP. I have read and I understand the Terms of Special Enrollment included on this form.

Bundled CHP Options: Bundled CHP Options include medical, dental and vision coverage.
Indicate your enrollment decision by checking the appropriate box below. If you elect to enroll in a Bundled CHP Option, please also select the Class of Coverage.

☐ Option A ☐ Option C ☐ Option E
☐ Option B ☐ Option D ☐ Option HDHP*

*If your Employer offers the same medical option through different carriers, select your carrier: ☐ BCBS ☐ UMR

Select one Class of Coverage that will apply to your Medical, Dental, and Vision coverage:
☐ Self Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self, Spouse & Child(ren)

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C Concordia Health Plan (Continued)

Unbundled CHP Medical Options: Unbundled CHP Medical Options are for Medical coverage only.
Indicate your enrollment decision by checking the appropriate box below. If you elect to enroll in an Unbundled CHP Medical Option, please also select the Class of Coverage.

☐ Healthy Me Copay A*	☐ Healthy Me HSA A*	☐ Whole Health
☐ Healthy Me Copay B*	☐ Healthy Me HSA B*	☐ Whole Health 1000
☐ Healthy Me Copay C*	☐ Healthy Me HSA C*	☐ Whole Health 2000
☐ Healthy Me Copay D*	☐ Healthy Me HSA D*	☐ Select HMO-C
☐ Healthy Me Copay E*	☐ Healthy Me HSA E*	☐ Select HMO-C 2000

* If your Employer offers the same medical option through different carriers, select your carrier: ☐ BCBS ☐ Cigna ☐ UMR

Select one Class of Coverage for your Medical coverage:
☐ Self Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self, Spouse & Child(ren)

Unbundled Dental Options: Unbundled Dental Options are for Dental coverage only.
Indicate your enrollment decision by checking the appropriate box below. If you elect to enroll in an Unbundled Dental Option, Please also select the Class of Coverage.

☐ Dental Basic ☐ Dental Plus ☐ Dental Premium

Select one Class of Coverage for your Medical coverage:
☐ Self Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self, Spouse & Child(ren)

Unbundled Vision Options: Unbundled Vision Options are for Vision coverage only.
Indicate your enrollment decision by checking the appropriate box below. If you elect to enroll in an Unbundled Vision Option, Please also select the Class of Coverage.

☐ Vision Basic ☐ Vision Premium

Select one Class of Coverage for your Medical coverage:
☐ Self Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self, Spouse & Child(ren)

D Reason for Non-Enrollment in the Concordia Health Plan

- ☐ I am covered under my spouse's or parent's group health plan (converge 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. Medicid), 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 _____

E 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
Were you placed recently at this employer by the Synod's Board of Assignments?.....	☐ Yes	☐ No

_____

Date of Assignment (MM/DD/YYYY) Date Studies Completed (MM/DD/YYYY) Name of LCMS School From Which You Graduated

Recent graduates assigned by the Synod's Board of Assignments are eligible for early enrollment in the CRP, CDSP and CHP effective the first of any month following the receipt of their assignment and graduation, but not later than their normal effective date. If desired, enter the early enrollment date here: _____

☐ As a minister of religion enrolled in the CRP prior to 1982, with participation terminated for no more than 5 years, 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.

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F Concordia Retirement Plan and Concordia Disability and Survivor Plan

If your employer has adopted the Concordia Retirement Plan (CRP) and the Concordia Disability and Survivor Plan (CDSP) and you meet the eligibility requirements, you will be enrolled in these plans. The plans are funded by your employer to provide you with enhanced financial security into retirement, should you experience a disabling event, or in the event of your or your enrolled dependents death. Therefore, it is important for you to list all your eligible dependents in Section B.

G Personal Spending Accounts

Your employer may offer tax-advantaged accounts to help you pay for out-of-pocket health care costs. These accounts include Limited Purpose Flexible Spending Accounts (LPFSA), Dependent Care Flexible Spending Accounts (DCFSA). Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA). Confirm with your employer which benefits are available to you and visit **ConcordiaPlans.org/enroll** or contact CPS at 888-927-7526 to access the appropriate enrollment form(s).

H Supplemental Life and Accidental Death and Dismemberment Insurance

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. Visit **ConcordiaPlans.org/enroll** or contact CPS at 888-927-7526 to access the appropriate enrollment form(s).

I Accidental Injury and Critical Illness Insurance

Your employer may offer these benefits which can provide lump sum payments for qualified expenses resulting from injury or illness. Confirm with your employer which benefits are available to you, and visit **ConcordiaPlans.org/enroll** or contact CPS at 888-927-7526 to access the appropriable enrollment form(s).

J 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)

Employer Representative Section

K Worker Employment and Compensation Information

Employer Name Employer ID Number

Address City State Zip Code

L Worker Employment and Compensation Information

Worker's Occupation Full-Time Hire Date (MM/DD/YYYY) Part-Time Hire Date (MM/DD/YYYY)

Be specific - e.g. Write Elementary Teacher instead of Teacher

This worker is an/a: ☐ Hourly worker ☐ Salaried worker ☐ Faculty

WORKER COMPENSATION	A	B	C	D	E	F
EMPLOYER/PARISH	Hours worked per week	Basic Annual Cash Salary	Calculate 25% Home Provided 25% Of Column B	Annual Cash Housing Allowance Paid to Worker	Annual Cash Utility Allowance Paid to Worker	Annual Total Compensation (B+C+D+E)
Dual Parishes Only--Enter Total Compensation Received						

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M	Employer 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 at 888-927-7526.

Please retain this sheet for your records.