Certification of Employer's Declaration of Hours

Employer's Election of Full-time Hours Required For Worker Eligibility to Participate in the CHP

Purpose of Certification

In an effort to help an employer serve the particular needs of its ministry, the Concordia Health Plan allows an employer to declare the number of hours a worker must be hired to work per week to be considered "full-time" to be eligible to participate in the CHP. An employer may change its designation at any time but not more than once in any calendar year.

Declaration of Hours Options

An employer has the option to declare the number of hours per week a worker must be hired to work in order to be eligible to participate in the CHP. The available options are more than 20 hours, more than 25 hours, more than 30 hours or 30 hours or more per week.

Regardless of an employer's declaration of hours worked per week, a worker must also be hired to work for more than five consecutive months to be eligible to enroll in the CHP.

Implementation

When submitting a new Certification of Employer's Declaration of Hours form, the change will be applicable to all workers, both current and newly employed, as of the effective date.*

All affected workers must be notified in advance of a change in CHP eligibility.

* The effective date will be the first of the month following Concordia Plan Services' receipt of a complete and properly authorized Certification of Employer's Declaration of Hours form which can be found on the reverse side of this document.

Important Notes

1. This election is only available for the CHP. The Concordia Retirement Plan and Concordia Disability and Survivor Plan both require enrollment for all workers who are hired to work more than 20 hours per week and for more than five consecutive months.
2. For employers who do not submit a Certification of Employer's Declaration of Hours form for the CHP, eligibility definition will default to workers hired to work more than 20 hours per week and for more than five consecutive months.
3. Implementation must be consistent and non-discriminatory for all workers.
4. In order to comply with the Employer-Shared Responsibility Mandate of the Affordable Care Act, employers defined as "applicable large employers" under this law (those with 50 or more full-time or full-time equivalent employees) should not select the "more that 30 hours" option.

Learn more:
ConcordiaPlans.org

11573-1024

CONCORDIA PLANS

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

CONCORDIA PLANS

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Certification of Employer's Declaration of Hours

Concordia Health Plan (CHP) Eligibility

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A Employer Information

Employer Name _____ Concordia Plan Services Employer Account Number (if known) _____

Address _____

City _____ State _____ Zip Code _____ Employer Phone Number _____

Employer E-mail Address _____ Employer Fax Phone Number _____

B Declaration of Hours

I, _____, an officer
Print Name of Officer, Title held at Employer

of the employer named above, do hereby certify to Concordia Plan Services that at a meeting of the Governing Body of this participating employer – as authorized by the Constitution and Bylaws of this organization – the following resolution was adopted.

Meeting date: _____20_____

RESOLVED, That this organization has elected to use the following definition of a full-time worker, for the purpose of establishing eligibility for Concordia Health Plan coverage, as *(Check one.)*

- ☐ more than 20 hours per week
- ☐ more than 25 hours per week
- ☐ more than 30 hours per week
- ☐ 30 hours per week or more

to be effective the first of the month following receipt of this declaration by Concordia Plan Services. It is also acknowledged that all workers affected by this action have been so notified of the change in Concordia Health Plan eligibility, and that this action does not change the definition of a full-time worker under the Concordia Retirement Plan or the Concordia Disability and Survivor Plan which is more than 20 hours per week and more than 5 consecutive months.

_____ (Initial here.) I understand this new hours declaration applies to all workers, and CHP coverage for any current worker who no longer meets the designated hours will be terminated.

C Employer Representative Signature

X _____

Signature of Authorized Employer Representative _____ Date _____

Printed Name of Authorized Employer Representative _____ Title or Office Held _____

E-mail Address of Authorized Employer Representative _____ Daytime Phone Number _____

Submit one copy of completed form to:

Concordia Plan Services, Attn: Enrollment Services, P. O. Box 229007, St. Louis, MO 63122-9007
or FAX to: 314-996-1127