Concordia Plan Services
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Concordia Health Plan
Special Enrollment Application Form

USE THIS FORM FOR ALL REQUESTS FOR ENROLLMENT EFFECTIVE AFTER 1/1/2025

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A Instructions

Workers: If you have recently experienced a special enrollment event, please complete Sections B - K and return this form to your employer.

If you are declining enrollment for any eligible dependents, please complete Section I, Reason for Non-Enrollment in the Concordia Health Plan (CHP).

Employers: Please complete Section L and submit the completed form to Concordia Plan Services.

This completed form must be received by Concordia Plan Services within 60 days of the special enrollment event or you and/or your dependents may be required to wait until the next Annual Open Enrollment period to request coverage under the CHP.

B Employer Information

Employer Name ____________________ Employer ID Number ____________________

Employer Address ____________________

City ____________________ State ________ Zip Code ________ Daytime Phone Number ____________________

C Worker Information

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

Home Address ____________________ City ____________________ State ________ Zip Code ________

Email Address ____________________ Daytime Phone Number ____________________

D Marital Status (MM/DD/YYYY)

- ☐ Single – Never Married
- ☐ Married, Date. . . . . ____________________
- ☐ Widowed, Date . . . . ____________________
- ☐ Divorced, Date . . . . ____________________
- ☐ Legally Separated, Date . . ____________________

E

Home Phone Number ____________________

Cell Phone Number ____________________

Fax Phone Number ____________________

Country in Which You Hold Citizenship ____________________

F Concordia Health Plan Election

Unbundled CHP Medical Options: Unbundled CHP Medical Options are for Medical coverage only. Check the box of the Unbundled CHP Medical Option you choose to enroll in:

Healthy Me Copay C*	Healthy Me HSA A*	Whole Health	Select HMO-C Select
Healthy Me Copay D*	Healthy Me HSA B*	Whole Health 1000	HMO-C 2000
Healthy Me Copay E*	Healthy Me HSA C*	Whole Health 2000	
Healthy Me Copay F*	Healthy Me HSA D*	Whole Health 3500	

* 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 Self and Spouse Self and Children Self, Spouse and Children

I decline enrollment in Unbundled CHP Medical Plan option

11041-1224

F Concordia Health Plan Election (continued)

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 Dental HMO

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

I decline enrollment in the Unbundled Dental Plan option.

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)

I decline enrollment in the Unbundled Vision Plan option.

G Dependent Information

If you are adding a Spouse or Child, the following information is required. To enroll your Child(ren), review 1 and 2 below to determine their eligibility as Dependents under the CHP. You may be required to submit a birth certificate or legal documentation. In certain situations, your grandchild or step-grandchild may be eligible to be enrolled as your Dependent—contact Concordia Plan Services at 888-927-7526 for information. (Note: A Spouse on active military duty is not eligible for CHP enrollment.)

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

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

- *If adding a foster child or legally adopted child, please include legal documentation.*
- *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.*
- *If listing more children than space provided, attach sheet giving information as requested below.*

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

H Important Notice Regarding Special Enrollment in The Concordia Health Plan

Are you requesting coverage for yourself and/or your eligible Dependents because you and/or your Dependent(s) were covered under another health plan and are now no longer eligible for such coverage? ☐ YES ☐ NO

If you check "yes," we must have a copy of the certificate of prior coverage for each individual for whom coverage is being requested. A COBRA extension form CANNOT be accepted as a certificate of prior coverage.

NOTE: If you are unable to promptly obtain a certificate of prior coverage, please submit this application within 60 days of the loss of other coverage and send a copy of the certificate of prior coverage once you have received it. The information submitted will be reviewed to determine special enrollment eligibility in the CHP. If all the requirements are met, eligibility for coverage will be the first day of the calendar month coinciding with or next following the loss of other coverage. This also applies to transferring Workers.

Please provide information regarding the other insurance:

____

Type of Policy (e.g., medical, dental, etc.)

____

Name of Insurance Company/Carrier | Policy Holder | Policy Number

____

Street Address

____

City | State | Zip Code | Phone Number

____

Date Other Coverage Began | Date Other Coverage Terminated | Reason Other Coverage Terminated

I Reason for Non-Enrollment in The Concordia Health Plan

Place a check mark on the line next to the reason you, your Spouse, or Dependent Child(ren) are declining CHP coverage.

Worker	Dependent Spouse	Dependent Child(ren)	
________	________	________	Covered under Spouse's or parent's group health plan (coverage by virtue of employment, including military service). (CODE 51)
________	________	________	Covered as a dependent under my Spouse who is also enrolled in CHP as a worker. (CODE 72)
________	________	________	Covered under a military plan (TRICARE) as a retiree, a state mandated health plan (e.g., Hawaii), or another country's mandatory health plan while residing outside the United States. (CODE 52)
________	________	________	Covered under a Medicare supplemental plan or other government plan (e.g., Medicaid).(CODE 63)
________	________	________	Covered under a former employer's health plan or COBRA plan. (CODE 64)
________	________	________	Covered under non-LCMS employer's health plan. (CODE 65)
________	________	________	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. (CODE 73)
________	________	________	Not eligible for enrollment at this time due to the number of hours worked. (CODE 55)
________	________	________	Other reason (CODE 70) ______________________________

J Terms of Special Enrollment

Special Enrollment: Workers and/or their eligible Dependent(s), who previously declined CHP coverage due to other coverage in another health plan, may be eligible to enroll in the CHP at a later date under the special enrollment provisions if they are eligible for coverage and the following conditions are met. Application for special enrollment in the CHP must be received by Concordia Plan Services **as soon as possible but no later than 60 days** after the event (i.e., loss of other health coverage or the reason for requesting CHP enrollment).

a. *Loss of other coverage.* To be eligible for the special enrollment period, the coverage must be lost due to a loss of eligibility for the other coverage or the employer contributions toward the other coverage must have ended. Loss of eligibility includes a loss of coverage due to divorce, legal separation, death, termination of employment, or reduction in hours of employment. Loss of coverage does not include a loss due to failure of the participant to pay premiums for any reason or termination of the other coverage for cause. **Any break in covered periods must be less than 63 days.**

b. *Children's Health Insurance Program (CHIP) Reauthorization Act of 2009.* A Worker (or Dependent) who is eligible, but not enrolled for coverage, may enroll for coverage if: (1) The Worker (or Dependent) is covered under a state Medicaid or state children's health insurance plan and coverage is terminated as the result of the loss of eligibility for Medicaid or state children's health insurance coverage; or (2) The Worker (or Dependent) becomes eligible for premium assistance to purchase coverage under the group health plan provided by the applicable state Medicaid or state children's health insurance plan; and (3) The Worker requests coverage **no later than 60 days** after the date eligibility is lost or the date the Worker (or Dependent) is determined to be eligible for state premium assistance.

c. *New Dependent due to marriage, birth, adoption, or placement for adoption.* 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/or 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 annual enrollment period.

d. *Certification.* A certificate of prior coverage or similar evidence of prior coverage must be submitted with the request for special enrollment. In lieu of a certificate of prior coverage, the individual may demonstrate prior coverage by (1) attesting to such coverage, (2) providing corroborating evidence (e.g., a doctor's bill or pay stub showing payroll deduction), and (3) cooperating with the plan to demonstrate coverage. *An individual who meets all three criteria will be treated as providing certification of prior coverage.*

K Worker Signature

The information entered on this form is current and correct to the best of my knowledge. I understand that any portion of the cost for participation that is my responsibility, according to the provisions of the Concordia Plans, will be obtained from me and remitted along with the portion required from my employer. I also agree to provide legal documentation of any dependent's relationship to me upon request.

X ______________________________

Signature of Worker — Date

L 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

Printed Name of Authorized Employer Representative — Title or Office Held

Email Address — Daytime Phone Number