



**Request For Membership
 Change**

USE THIS FORM FOR ALL ENROLLMENT CHANGES EFFECTIVE PRIOR TO 1/1/2025

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Instructions

Please indicate below what's changing. Check all that apply.

Member Changes:

- Marriage – Review and complete sections A-E and G-K.
- Birth/Adoption – Review and complete sections A-E and G-K.
- Address – Review and complete sections A and K.
- Termination of the Concordia Health Plan (CHP) for yourself or your dependents – Review and complete sections, A, F and K.
- Other - Please list: _____

Employer Changes:

- Rostered Status – Review and complete sections A, L, M and O.
- Salary (applicable only if due to a change in duties or hours), Duties/Job title, Hours or Employment Classification - Review and complete sections A, L, N and O.
- Other - Please list: _____

Member Section

A Member Information

Title	Last Name	First Name	Middle Initial	Suffix	Previous Last Name
Address		City	State		Zip Code
Last 4 Digits of SSN	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 your dependents, including your spouse. If listing more dependents than the space provided, attach a sheet giving information as requested below. All eligible dependents listed below will be enrolled in CDSP.

Dependent's Full Name <small>(Last - if different than yours, First, Middle Initial)</small>	Relationship	Sex <small>(M/F)</small>	Date of Birth <small>(MM/DD/YYYY)</small>	Social Security Number	Enroll In:		
					Medical	Dental	Vision
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C Concordia Health Plan - Waive

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 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 E.

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

D **Concordia Health Plan - Enroll**

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)

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 Dental 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 Vision coverage:

- Self Only Self & Spouse Self & Child(ren) Self, Spouse & Child(ren)

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 check all that apply and complete the information as requested below.

I'd like to terminate CHP for myself.

Please complete section E and list the termination effective date (MM/DD/YYYY): _____

I'd like to terminate CHP for my dependent(s).

Please complete the information below. If listing more dependents than space provided, attach additional sheet with the requested information.

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	
		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____			
		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____			
		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 _____			

G 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.

H 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).

I 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).

J 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 appropriate enrollment form(s).

K 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)

