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

CONCORDIA PLANS

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

# Request For Membership Change

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

## 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 (Last - if different than yours, First, Middle Initial) | Relationship | Sex (M/F) | Date of Birth (MM/DD/YYYY) | Social Security Number | Enroll In: Medical | Dental | Vision |
|---|---|---|---|---|---|---|---|
| | | | | | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ |
| | | | | | ☐ | ☐ | ☐ |

### 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.

*(Continued on next page)*

## 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 _____

***(Continued on next page)***

## 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 | |
| | | ☐ 1 ☐ 2 ☐ 3 ☐ 4 _____ | ☐ | ☐ | |
| | | ☐ 1 ☐ 2 ☐ 3 ☐ 4 _____ | ☐ | ☐ | |
| | | ☐ 1 ☐ 2 ☐ 3 ☐ 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 appropriable 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)

***(Continued on next page)***

## Employer Section

### L Employer Information

Employer Name _____ Employer ID Number _____

Address _____ City _____ State _____ Zip Code _____

### M Minister of Religion

Will the worker's name appear on the Synod's Roster of Ordained and Commissioned Ministers of Religion? ☐ Yes ☐ No

Will the worker 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, the worker requests enrollment in the CRP Traditional Option on the Full Basis.

### N 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 | ☐ | | | | New Job Title: | | | | |
| Hours | ☐ | | | | Hours Worked per Week Changed to: | | | | |
| Employment Classification | ☐ | | | | Employment:<br>This worker is a/an: ☐ Hourly Worker ☐ Salaried Worker<br>Job Designation: ☐ Faculty ☐ Non-Faculty<br>Pay Frequency: ☐ Bi-Weekly (26) ☐ Monthy (12)<br>☐ Weekly (52) ☐ Semi-Monthly (24) | | | | |

### O 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.

***Member: Please retain this sheet for your records.***