Concordia Plan Services
The Lutheran Church—Missouri Synod
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CONCORDIA PLAN SERVICES

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Enrollment Form

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A Employer Information

Employer Name ______ Employer ID Number ______

Address ______

City ______ State ______ Zip Code ______ Employer Phone Number ______

Employer District Affiliation ______ Employer E-mail Address ______ Employer Fax Phone Number ______

Worker's Occupation ______

Scheduled No. of Hours per Week* ______

Full-Time Hire Date (MM/DD/YYYY) ______

Part-Time Hire Date (MM/DD/YYYY) ______

Is worker hired to work more than 5 consecutive months? ☐ Yes ☐ No
Is this worker deployed (works at location other than employer)? ☐ Yes ☐ No
Does a probationary period apply for benefits? ☐ Yes ☐ No
This worker is an/a: ☐ Hourly worker ☐ Salaried worker

*Any worker hired to work more than 20 hours per week AND more than five consecutive months is required to be enrolled in the Concordia Retirement Plan (CRP) and the Concordia Disability & Survivor Plan (CDSP).

Any worker who is hired to work the minimum number of hours required for Concordia Health Plan (CHP) benefits, as designated by the employer's ***Declaration of Hours Form*** on file at CPS, AND for more than five consecutive months is eligible to enroll in the CHP.

Plan benefits normally begin the first day of the month following a worker's hire date unless a Probationary Period Certification is on file at CPS. A worker's part-time employment period counts toward satisfaction of any probationary period established and on file with CPS.

B Worker Information

☐ Rev. ☐ Mrs.
☐ Dr. ☐ Miss
☐ Mr. ☐ Ms.

Worker's Name (Last, First, Middle Initial) ______ Previous Last Name ______

☐ Junior ☐ Senior
☐ II ☐ III
☐ Other: ________

C

U.S. Social Security Number ______ Canada Social Insurance Number ______

D

Date of Birth (MM/DD/YYYY) ______

E Gender

☐ Male ☐ Female

F

Worker's Address ______

City ______ State ______ Zip Code ______

G Marital Status (MM/DD/YYYY)

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

H

Home Phone Number ______

Cell Phone Number ______

Fax Phone Number ______

E-mail Address ______

Country in Which You Hold Citizenship ______

I Spouse Information

If you are married, please complete this section.

Spouse's Name (Last - if different than yours, First, Middle Initial) ______

Date of Birth (MM/DD/YYYY) ______ U.S. Social Security Number ______ Canada Social Insurance Number ______

Spouse's LCMS Employer Name (if applicable) ______ City ______ State ______ Zip Code ______

Date Spouse's LCMS Employment: Began (MM/DD/YYYY) ______ Terminated (MM/DD/YYYY) ______ Is Scheduled to Begin (MM/DD/YYYY) ______

J Previous Enrollment Information

If you and/or your spouse were previously enrolled in the Concordia Plans as a worker or ***dependent*** *of a current/previous LCMS worker, please list that worker's name below. (List could include mother, father, foster parents, stepparents, legal guardian, previous spouse, etc., if ever employed by LCMS.)*

Relationship	Last Name	First Name	LCMS Employer	LCMS Employment is:
			Name City/State	☐ Current ☐ Terminated (Yr.)
			Name City/State	☐ Current ☐ Terminated (Yr.)

K Child(ren) Information

You must complete this section to enroll your eligible child(ren). Failure to enroll your eligible child(ren) will result in decreased or lost benefits. A "child" shall mean your biological, legally adopted, step, and foster child. 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. Please carefully read the following:

Concordia Disability and Survivor Plan (CDSP) - Life Insurance Benefits

Please list your eligible child(ren) as described in 1, 2, and 3 below. Enrolling eligible children provides life insurance protection for them. Please note that there are different eligibility requirements for the CDSP than the Concordia Health Plan. To be eligible under the CDSP, the child must qualify as your dependent for federal income tax purposes (or would qualify as such a dependent, but for exceeding applicable age or earning limits).

1. Your unmarried child under age 21.
2. Your unmarried child age 21 up to age 27 if a full-time student in an accredited educational institution.
3. Your unmarried child who is 21 or over AND became totally disabled prior to attaining age 21 or became totally disabled while a full-time student at an accredited educational institution (subject to approval).

Note: If both parents are active workers enrolled in the CDSP, each parent should enroll the dependent child(ren) in the CDSP.

Concordia Health Plan (CHP) - Medical, Dental, Prescription, etc., Benefits

To enroll your child(ren), review 4 and 5 below to determine their eligibility as dependents for the CHP. You may be required to submit a birth certificate or legal documentation.

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

THE FOLLOWING CHILD(REN) IS/ARE TO BE ENROLLED IN THE CDSP AND/OR 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	Gender	Date of Birth	Social Security Number	Enroll in CHP | CDSP
					☐ | ☐
					☐ | ☐
					☐ | ☐
					☐ | ☐
					☐ | ☐
					☐ | ☐

L Concordia Health Plan Enrollment

All eligible workers of a participating employer may enroll themselves and any eligible dependents in the Concordia Health Plan (CHP). (Ask your employer representative if you have any questions about the minimum eligibility requirements for health coverage.) Application for CHP enrollment must be made within 60 days of the initial eligibility date, otherwise late enrollment rules apply and coverage may be denied. In addition to any eligible children, your spouse is eligible to be enrolled as your dependent regardless of his/her eligibility to be enrolled in the CHP as a worker. If your spouse is in active military service, he/she is not eligible to be enrolled in the CHP as your dependent.

L Concordia Health Plan Enrollment (Cont.)

IMPORTANT NOTICE

If you and/or your eligible spouse and/or eligible children do not enroll at this time, the "Reason for Non-Enrollment", Section M below, must be completed. Any future request for CHP enrollment for you and/or your eligible dependent(s) will be subject to the plan provisions in effect at the time coverage is requested, which may include having to wait for an open enrollment period or satisfying requirements for a special enrollment date.

☐ **YES, I wish to enroll in the CHP.**

Check one class of coverage.

☐ Self Only (Class 1) ☐ Self and Spouse (Class 2) ☐ Self and Children (Class 3) ☐ Self, Spouse, and Children (Class 4)

If you checked "Yes" and your employer offers Employer Choice, you will be enrolled in the option your employer has elected; If your employer offers Worker Choice, please check your desired plan coverage option (you can only elect an option being offered by your employer):

☐Option A ☐Option B ☐Option C ☐Option D ☐Option E ☐Option HDHP ☐Option HMO ☐Option HMO-C ☐Option HMO-C2

☐Select 500 ☐Select 1000 ☐Choice 1500 ☐Choice 2000

☐ **NO, I do not wish to enroll in the CHP.**

Check "No" if you are declining coverage for any reason including: not eligible to enroll in the CHP or if you electing to enroll as a dependent under your spouse who also has coverage in the CHP. Be sure to select applicable reason for declining coverage in Section M.

M 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) ____________________

N 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. *Statement of reason for declining coverage.* The worker must provide a statement at the time coverage is declined indicating the reason for declining coverage. **Any break in covered periods must be less than 63 days.**

b. *COBRA coverage exhausted.* If coverage was declined for a worker and/or any dependent(s) because the other coverage was COBRA continuation coverage, the COBRA continuation coverage must be exhausted before the special enrollment will be available. **Any break in covered periods must be less than 63 days.**

c. *Loss of other coverage.* If the other coverage that applied to the worker and/or any dependent(s) when enrollment was declined was not COBRA continuation coverage, then 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.**

d. *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.

e. *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 enrollment period.

f. *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.*

O Accident Insurance Program

All full-time workers are eligible to enroll if their employer is participating in any of the Concordia Plans and agrees to remit payments. The employer is not required to pay any portion of the cost of this coverage, although they may do so if they desire. Please refer to ***ConcordiaPlans.org,*** Disability and Survivor, Accident Insurance for further information and rates. Accident Insurance Program (AIP) eligibility requirements for children follow the same guidelines as the Concordia Disability and Survivor Plan (CDSP).

☐ **YES** Enroll me in the Plan selected.
Check one box to the right.

☐ **NO** Do not enroll me.

INSURANCE AMOUNT	INDIVIDUAL PLAN	FAMILY PLAN
$ 300,000	☐ 1J	☐ 2J
$ 250,000	☐ 1I	☐ 2I
$ 200,000	☐ 1H	☐ 2H
$ 175,000	☐ 1G	☐ 2G
$ 150,000	☐ 1F	☐ 2F
$ 125,000	☐ 1E	☐ 2E
$ 100,000	☐ 1D	☐ 2D
$ 75,000	☐ 1C	☐ 2C
$ 50,000	☐ 1B	☐ 2B
$ 25,000	☐ 1A	☐ 2A

P Ministers Of Religion

Were you placed recently at this employer by the Synod's Board of Assignments? ☐ Yes ☐ No
If yes, insert the information requested below.

Date of Assignment ____________ Date Studies Completed ____________

Name of LCMS School From Which You Graduated ____________

Q LCMS Lutheran Annual Listing

Check the listing under which your name appears or will appear in the LCMS Lutheran Annual. If this does not apply to you, please check the "None of the Above" box.

☐ Ordained Minister of Religion—Pastor
☐ Commissioned Minister of Religion (select one below)
- ☐ Teacher
- ☐ DCE
- ☐ Deaconess
- ☐ Parish Assistant
- ☐ Director of Family Life Ministry
- ☐ Director of Christian Outreach
- ☐ Director of Parish Music
- ☐ Lay Minister

☐ None of the Above

R Self-Employment Social Security Tax

Do you pay, or will you be paying "Self-Employed" Social Security tax? ☐ Yes ☐ No

S Early Enrollment Date for Assigned Worker

To be completed by the employer representative.

This section is applicable only if the worker is a new graduate assigned by the Synod's Board of Assignments. Such a worker will normally be enrolled the first day of the month after reporting for work at the employer, as are other workers. However, the employer may request that such a worker be enrolled at an earlier date, as permitted within the plan provisions for newly assigned graduates. The earlier date of enrollment, if requested by the employer, will be the first day of any month following the date all academic requirements for graduation were completed and the graduate was assigned. However, the date cannot be later than the first day of the month following the date that the individual reports for work.

If an early enrollment date is desired, enter the month enrollment is to be effective: ____________

T Concordia Retirement Plan Participation Basis

Ordained and commissioned ministers of religion (1) who were participating in the Concordia Retirement Plan (CRP) on December 31, 1981; (2) who were deemed to be a self-employed person under Social Security laws and whose self-employed status did not subsequently terminate; and (3) whose participation in the CRP as a worker has not subsequently terminated for a period of more than five years may be eligible to participate in the CRP on a FULL BASIS. Any worker enrolled in the CRP on or after January 1, 1982 is not eligible for the FULL basis.

☐ *Check here if this option is available to you and you wish to elect it.*

U Worker Compensation Information

To be completed by the employer representative.

The compensation information you provide will be used as the basis for Retirement, Disability and Death Benefits for this worker, and for billing purposes for the CRP and CDSP. Carefully follow the directions on pages 5-6. If your congregation is part of a dual parish, report compensation information received from each congregation separately as shown in examples on the last pages of this form.

		B	C/D		E	F
Employer Account Number (if known)	LCMS Employer	Annual Cash Salary Paid Over 12-Month Period	Annual Amount for Housing if Home Provided (25% of Column B)	Annual Amount for Housing if Cash Paid to Worker	Annual Cash Utility Allowance Paid to Worker	Total Compensation Column B-C/D-E
	Name: City/State:					
	Name: City State:					
Dual Parishes Only—Enter Total Compensation Received						

11010-0516

V Worker Signature

The information entered on this form is current and correct to the best of my knowledge.

- I authorize my employer to obtain any portion of the cost required from me, according to the Plan provisions, for my participation in the Concordia Health Plan (CHP) or the Accident Insurance Program (if applicable), and to remit such portion along with the portion required of my employer to Concordia Plan Services.
- I agree to provide legal documentation of any dependent's relationship to me upon request. I also agree to notify Concordia Plan Services immediately of any eligibility changes for my dependents in the future.
- If I decline or later request to terminate the CHP coverage for myself or any of my dependents, I understand that any future request for enrollment in the CHP will be delayed until an open enrollment period is provided, unless I and/or my eligible dependent(s) become eligible for "special enrollment" as outlined in Section N, "Terms of Special Enrollment."

X ____

Signature of Worker Date

W 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

X Employer's Instructions For Entering Compensation Information

COLUMN B – BASIC ANNUAL CASH SALARY. Enter the basic annual cash salary in effect on **the date of hire**.

DO include: Amounts withheld through salary reduction for a 403(b) annuity, contract, or plan; including the Concordia Retirement Savings Plan

Amounts withheld through salary reduction for a Cafeteria Plan or Section 125 plan

DO NOT include: A car or travel allowance

A Social Security or FICA allowance

Salary adjustments that may be given after January 1

A cash housing or utility allowance (these will be reported in Columns D and E)

Amounts paid to a Minister of Religion for the difference between the Regular and Full Basis rates for the CRP

- If you have workers who are paid on an hourly basis, their annual salaries can be determined by multiplying their hourly wage by the number of hours it is estimated they will work during a 12-month period.
- If you have a worker receiving compensation from two or more congregations, only one form is required. (List the compensation being paid by each congregation; see examples on the reverse side of this sheet.) If your Dual Parish status has changed, request and submit a "Designation of Contact Congregation" form.
- If you have workers who earn their entire annualized compensation over a compressed work year, (e.g. teachers), please report the compensation they earn for the entire year, regardless of how it is paid out.

COLUMN C – HOME PROVIDED. If a parsonage or other type of employer-owned housing is provided for the worker to live in as his/her primary residence and the worker does not pay rent, enter 25% of Column B in Column C for the employer that owns the residence. (Please note that if a husband and wife are both enrolled and residing in a home provided by the same employer, an amount should be entered in this column only for the individual whose compensation agreement with the employer includes the housing provision.) If no employer-owned housing is provided for the worker, leave this column blank. If there is a dual parish relationship, please use the examples cited below to determine whether and how each parish should report an amount for provided housing.

COLUMN D – CASH HOUSING ALLOWANCE. If a CASH allowance is paid directly to a worker by the employer for housing, enter the annual amount in this column. (It is possible that a worker is provided free residence and paid a cash housing allowance. In that case, figures should be entered in both Column C and Column D.) If no cash housing allowance is paid to the worker, leave this column blank.

COLUMN E – CASH UTILITY ALLOWANCE. If a CASH allowance is paid directly to the worker for utilities, enter the annual amount in this column. (DO NOT include utility payments made directly to the utility company by the employer). If no cash utility allowance is paid to the worker, leave this column blank.

COLUMN F – TOTAL COMPENSATION. Add columns B, C, D, and E and enter the total in this column. A FIGURE MUST BE ENTERED in COLUMN F because payments for participation in the Concordia Retirement Plan and Concordia Disability and Survivor Plan are based on this amount, as are the payments of many benefits.

Examples for Multiple Parish Compensation Reporting

Example 1 – Both Congregations Provide a Cash Housing Allowance

	A	B	C	D	E	F
Worker's Name and Identification Number	**Hours Worked per Week**	**2016 Basic Annual Cash Salary**	**Home Provided 25% of Column B**	**Annual Cash Housing Allowance**	**Annual Cash Utility Allowance Paid to Worker**	**2015 Total Salary B+C+D+E**
JONES, ROBERT C.						
St. John	20	17,000		4,500	1,200	22,700
Trinity	20	15,000		3,500	1,200	19,700
		32,000		8,000	2,400	42,400

Example 2 – Only One Congregation Provides a Home

	A	B	C	D	E	F
Worker's Name and Identification Number	**Hours Worked per Week**	**2016 Basic Annual Cash Salary**	**Home Provided 25% of Column B**	**Annual Cash Housing Allowance**	**Annual Cash Utility Allowance Paid to Worker**	**2015 Total Salary B+C+D+E**
SMITH, DAVID A.						
Grace	35	25,000	6,250	900	900	33,050
Immanuel	15	10,000	0	0	0	10,000
		35,000	6,250	900	900	43,050

Example 3 – Congregations Share Ownership of Residence, or One Employer Owns Residence but the Other Employer Shares Expenses Such as Mortgage Payments, Repairs, Taxes, or Maintenance.

	A	B	C	D	E	F
Worker's Name and Identification Number	**Hours Worked per Week**	**2016 Basic Annual Cash Salary**	**Home Provided 25% of Column B**	**Annual Cash Housing Allowance**	**Annual Cash Utility Allowance Paid to Worker**	**2015 Total Salary B+C+D+E**
MEYER, JAMES P.						
Christ	20	17,000	4,250		900	22,150
Good Shepherd	20	15,000	3,750		900	19,650
		32,000	8,000		1,800	41,800

Example 4 – One Parish Owns Home but Second Parish Pays a Cash Housing Allowance Directly to Worker

	A	B	C	D	E	F
Worker's Name and Identification Number	**Hours Worked per Week**	**2016 Basic Annual Cash Salary**	**Home Provided 25% of Column B**	**Annual Cash Housing Allowance**	**Annual Cash Utility Allowance Paid to Worker**	**2015 Total Salary B+C+D+E**
SCHMIDT, THOMAS C.						
Holy Cross	20	17,000	4,250		1,000	22,250
Zion	20	16,000		900	1,000	17,900
		33,000	4,250	900	2,000	40,150

Note: If you have dual income for a worker, the information is needed to determine which employer is providing housing allowance and to ensure correct billing continues, if the dual arrangement ends. The worker's employing organization (primary) must officially designate the allowance as a housing allowance before paying it to the minister.