Concordia Plan Services
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Concordia Health Plan (CHP)
Enrollment Form for Retired Members

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A Retired Member Information

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

Home Address ______ City ______ State ______ Zip Code ______

E-mail Address ______

B Marital Status (MM/DD/YYYY)

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

C

Home Telephone Number ______

Cell Telephone Number ______

Country in Which You Hold Citizenship ______

D Concordia Health Plan Election

Retired Member

Please check the desired level of coverage for yourself from the following:

☐ Self Only
If age 65 or older: ☐ Medicare Supplemental Option

If under age 65, please check your desired plan coverage option from the following options offered (individual deductible amount in parenthesis):

☐ Option A ($0)
☐ Option B ($350)
☐ Option C ($600)
☐ Option D ($1,200)
☐ Option E ($1,800)
☐ Select 500 ($500)
☐ Select 1000 ($1,000)
☐ Option HDHP ($2,850)
☐ Option HMO (no deductible)*
☐ Option HMO-C (no deductible)*
☐ Option HMO-C2 (no deductible)*
☐ Choice 1500 ($1,500)
☐ Choice 2000 ($2,000)
* Only in limited areas

Dependent(s)

Please check the desired level of coverage for your dependent(s) from the following:

☐ Spouse Only ☐ Child(ren) Only ☐ Spouse and Child(ren)
If age 65 or older: ☐ Medicare Supplemental Option

If under age 65, check the desired plan coverage option from the following options offered (individual deductible amount in parenthesis):

☐ Option A ($0)
☐ Option B ($350)
☐ Option C ($600)
☐ Option D ($1,200)
☐ Option E ($1,800)
☐ Select 500 ($500)
☐ Select 1000 ($1,000)
☐ Option HDHP ($2,850)
☐ Option HMO (no deductible)*
☐ Option HMO-C (no deductible)*
☐ Option HMO-C2 (no deductible)*
☐ Choice 1500 ($1,500)
☐ Choice 2000 ($2,000)
* Only in limited areas

E 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 for the CHP. 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. You may be required to submit a birth certificate or legal documentation.

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 listing more dependents than space provided, attach sheet giving information as requested below.*
- *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 in writing to Concordia Plan Services.*

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

(Continued on reverse side)

F Request for Information Regarding Prior Health Coverage

If you are using this form to enroll a newly acquired spouse (e.g., through marriage) or child (e.g., through birth or adoption), you do not need to complete this section. Please continue to Section G.

If you are requesting enrollment in the Concordia Health Plan for yourself and/or your eligible dependents listed on the front page of this form for the following reasons, please complete this section of the form and provide the documentation indicated.

	Yes	No
Are you requesting coverage for yourself and/or eligible dependents because you and/or your dependents are age 65 or older and were covered:		
• By a health plan providing essential benefits required by Affordable Care Act (ACA).	☐	☐
If "Yes," has continuous coverage been maintained in a health plan providing essential benefits required by ACA for five continuous years prior to your request for reenrollment in Concordia Health Plan (CHP)? ***(Please provide documentation verifying five continuous years of coverage in health plan providing essential benefits required by ACA.)***	☐	☐
Are you requesting coverage for yourself and/or your eligible dependents because you and/or your dependent(s) were covered:		
• By a Medicare Advantage plan sponsored and approved by the government?	☐	☐
If "Yes," has continuous coverage been maintained in a Medicare Advantage Plan since you previously terminated your enrollment in the Concordia Health Plan? ***(Please submit documentation verifying continuous coverage in a Medicare Advantage Plan.)***	☐	☐
Are you requesting coverage because your spouse was covered:		
• By another health plan where the spouse was employed and is no longer eligible for such coverage due to retirement?	☐	☐
If "Yes," does that employer offer post-retirement health coverage (other than COBRA)? ***(Please submit proof of prior coverage and written notification from your spouse's employer stating no post-retirement health coverage is offered.)***	☐	☐

Please provide information regarding the other insurance:

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

Name of Insurance Company/Carrier ______ Phone Number ______

Street Address ______ City ______ State ______ Zip Code ______

Date Other Coverage Began ______ Date Other Coverage Terminated ______

Reason Other Coverage Terminated ______

G Retired Member Signature

The information entered on this form is current and correct to the best of my knowledge. I understand that the cost for participation in the Concordia Health Plan is my responsibility. I agree to provide legal documentation of any dependent's relationship to me upon request.

X ______

Signature of Retired Member ______ Date ______

Note: If you would like to have the cost of CHP coverage deducted from your bank account, please visit our website, www.ConcordiaPlans.org, to access the Online Payment System. You can also have the cost of coverage deducted from your monthly benefits from the Concordia Retirement Plan, if available.

All post-retirement questions regarding Concordia Health Plan enrollment should be directed to Concordia Plan Services. Call toll-free 888-927-7526 or send an e-mail to info@ConcordiaPlans.org.