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

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Concordia Health Plan
2017 Annual Open Enrollment

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Instructions

If you are an eligible Worker at a participating Employer in the Concordia Health Plan (CHP) but you and/or your Dependents are not currently enrolled in the CHP, you and/or your eligible Dependents may enroll in the CHP through Annual Open Enrollment. If you are currently enrolled in the CHP and wish to terminate your and/or your Dependent(s) coverage, you may also use this form to stop participation effective December 31, 2016.

Workers: Please complete Sections A-F and return this form to your Employer. If you are enrolling in any of the other Concordia Plans, please also submit a completed Enrollment Form. NOTE: If your Employer offers a Personal Spending Account (PSA) like a Flexible Spending Account (FSA), Health Savings Account (HSA), or Health Reimbursement Arrangement (HRA), you may need to complete a separate form for that program. Contact your Employer for details.

If you are not requesting enrollment for one or more eligible Dependents, complete Section E, Reason for Non-Enrollment in the Concordia Health Plan.

If your marital status has changed, please submit a completed Request for Membership Change form.

Employers: Please complete Section G and submit the completed form to Concordia Plan Services. This form must be received by Concordia Plan Services no later than October 14, 2016. If the form is received by the deadline date, a Worker's and/or an eligible Dependent's enrollment in the Concordia Health Plan becomes effective January 1, 2017.

A 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 _____

B Concordia Health Plan Coverage Option

Your Employer has determined your CHP coverage Option(s). Check with your Employer representative if you have questions about your 2017 CHP Option.

C Concordia Health Plan Coverage Level

Please check your desired level of coverage. If you are adding or removing Dependent(s) from coverage, please complete Section D.

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

☐ I want to terminate my CHP coverage effective December 31, 2016. *(Complete Section E)*

D 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. 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.

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

If you are removing Dependent(s) from your CHP coverage list their information below, check the box next to "Remove", and complete Section E.

- *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	
				☐ Remove
				☐ Remove
				☐ Remove

X _____
Signature of Worker Date

(Continued on reverse side)

E Reason For Non-Enrollment in The Concordia Health Plan

Place a check mark on the line next to the reason if you, your Spouse, or Dependent Child(ren) are opting out of 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 a 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)
☐	☐	☐	Other reason (CODE 70) _____

F Worker Signature

The information entered on this form by me is current and correct to the best of my knowledge. I authorize my Employer to obtain any portion of the cost required by me (if applicable), according to the Plan provisions, for my participation in any of the Concordia Plans, and to remit such portion along with the portion required of my Employer. I agree to provide legal documentation of any Dependent's relationship to me upon request. I also understand that any and all changes listed on this form will be effective January 1, 2017.

If terminating CHP coverage, or declining enrollment for one or more eligible Dependents, I understand any future request for CHP enrollment for me and/or my 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.

X _____

Signature of Worker — Date

G Employer Information & Signature

As the Employer representative, I acknowledge that the information entered on this form for this Worker is complete and accurate to the best of my knowledge.

Employer Name — Employer ID Number

Employer Address

City — State — Zip Code — Daytime Phone Number

Printed Name of Authorized Employer Representative — Title or Office Held

X _____

Signature of Authorized Employer Representative — Date

Workers should return this form to their congregational treasurer, business manager, or HR office by the requested deadline.
Employers must have enrollment information to Concordia Plan Services by October 14, 2016.

Please make sure that all requested information is provided on this form;
missing information will delay the processing of the application or may result in the application being denied.