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

CONCORDIA PLAN SERVICES

Request for Membership Change

Toll Free: 888-927-7526
St. Louis: 314-965-7580
Fax: 314-996-1127
E-mail: info@ConcordiaPlans.org
Website: ConcordiaPlans.org

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A Instructions

Instructions for Member and Employer

1. To report a marital status change, or request health plan coverage for your spouse, complete Sections B—F, O, and P and review Sections J, K, L, and M.
2. To report a dependent child, complete Sections B—E, G, O, and P and review Sections J, K, L, and M.
3. To terminate your health coverage, complete Sections B—E, H, J, O, and P and review Section L.
4. To delete dependents no longer eligible or for whom coverage is no longer desired, complete Sections B—E, I, J, O and P and review Sections K, L and M.
5. To change your basis of participation in the Retirement Plan, complete Sections B—E, and N—P.

B Employer Information

Employer Name _______________ Employer ID Number _______________

Employer Address _______________

City _______________ State _______________ Zip Code _______________ Daytime Phone Number _______________

C Member Information

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

Home Address _______________ City _______________ State _______________ Zip Code _______________

E-mail Address _______________ Daytime Phone Number _______________

D Marital Status (MM/DD/YYYY)

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

E

Home Phone Number _______________

Cell Phone Number _______________

Fax Phone Number _______________

F Request to Enroll Spouse

If you are reporting a marital change or adding coverage for your spouse, please complete this section.

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

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

Are you requesting health coverage for your spouse? ☐ Yes ☐ No*

**If "No," please complete Section J, "Reason for Non-Enrollment in Concordia Health Plan" and review Section K, "Terms of Special Enrollment."*

A spouse in active military service is not eligible for enrollment under the Concordia Health Plan.

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) _______________

*If your spouse was previously enrolled in the Concordia Plans as a **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.)

11171-0616

G Request to Enroll Child(ren)

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).

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
					☐ | ☐
					☐ | ☐
					☐ | ☐
					☐ | ☐
					☐ | ☐

H Request to Terminate Concordia Health Plan Coverage

☐ Please terminate my participation in the Concordia Health Plan (CHP). Sections J, O, and P must also be completed. I understand that I have 30 days from the date that I want my coverage to terminate to submit this form to Concordia Plan Services (CPS) otherwise my coverage will terminate at the end of the month in which CPS receives the form and contributions will be due through that date.

____
Requested Termination Date

I Request to Terminate Dependent Coverage

I understand that I have 30 days from the date that my dependent is no longer eligible or that I desire coverage to terminate to submit this form to Concordia Plan Services otherwise coverage will terminate at the end of the month in which Concordia Plan Services receives the form and contributions will be due through that date. Sections J, O, and P must also be completed in order to preserve your dependents' special enrollment rights in the future.

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 Occurred (MM/DD/YYYY)
			CHP	CDSP	
		☐ 1 ☐ 2 ☐ 3 ☐ 4 __________			
		☐ 1 ☐ 2 ☐ 3 ☐ 4 __________			
		☐ 1 ☐ 2 ☐ 3 ☐ 4 __________			
		☐ 1 ☐ 2 ☐ 3 ☐ 4 __________			
		☐ 1 ☐ 2 ☐ 3 ☐ 4 __________			

J 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 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) ________________________________

K 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. *Loss of other coverage.* To be eligible for the special enrollment period, 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.**

c. *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.

d. *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.

e. *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.*

L Request to Change Beneficiary Designation

If you wish to make a change in your beneficiary for the Concordia Disability and Survivor Plan and/or Accident Insurance Program, the applicable form must be completed. If such form is not enclosed, please request a form from Concordia Plan Services, or you can print one from our website under Ministry Resources>Forms & Publications>Plan Member.

M Request to Change Accident Insurance Program Participation

☐ I wish to change my participation in the Accident Insurance Program (AIP). (*Check one box next to Plan desired from those listed to the right.)*

Change effective the first of the month after this form is received by Concordia Plan Services (CPS)

☐ I request enrollment in the AIP.
(*Check one box next to Plan desired from those listed to the right.)*

Enrollment effective the first of the month after this form is received by CPS

☐ I wish to terminate my enrollment in the AIP.

Termination effective the end of the month in which this form is received by CPS.

Individual 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

N Request to Change Retirement Plan Participation

Full Basis is available only for a minister of religion (a) who was a Concordia Retirement Plan (CRP) member and deemed to be a self-employed person under Social Security on December 31, 1981; (b) whose self-employed status has not subsequently terminated; and (c) whose participation in the CRP as a worker has not subsequently terminated for a period of more than five years.

Please change participation to ________________________________ basis effective ___________________________.
Enter either (full) or (regular) — Enter first day of any calendar month

O Member 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 also 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 requested 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 K, "Terms of Special Enrollment."

X ____

Signature of Member — Date

P Employer Representative Signature

The employment 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 required from the worker, according to the Plan provisions, for the worker's participation in the Concordia Health Plan or the Accident Insurance Program (if applicable), and to remit such portion along with the portion required by us as an employer.

X ____

Signature of Authorized Employer Representative — Date

____

Printed Name of Authorized Employer Representative — Title or Office Held

____

E-mail Address — Daytime Phone Number