Concordia Plan Services
The Lutheran Church—Missouri Synod
PO Box 229007
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CONCORDIA PLAN SERVICES

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Website: ConcordiaPlans.org

Newborn Enrollment

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A Instructions

- Enrollment of an eligible dependent in any Plan is not automatic and only occurs after we receive this properly completed form within 60 days of your newborn's date of birth.
- This form should be completed regardless of whether you want Concordia Health Plan coverage for this child. The child may be eligible for enrollment as your dependent under the Concordia Disability and Survivor Plan at no cost to you.
- Do not wait for a Social Security number (SSN) to be issued to enroll the child. Once the newborn's SSN is issued, please submit it in writing to Concordia Plan Services.
- Please return this form in the envelope provided or you may send a confidential fax to (314) 996-1127.

B Worker Information

Worker's Name (Last, First, Middle Initial) ______ Worker's Social Security Number ______

Address ______

City ______ State ______ Zip Code ______ Daytime Phone Number ______

C Newborn Information

Newborn's Name (Last, First, Middle Initial) ______ Newborn's Social Security Number (if available) ______

Date of Birth (MM/DD/YYYY) ______ Gender (Male or Female) ______

D Benefit Plan Enrollment

Concordia Disability and Survivor Plan (CDSP)-Death Benefits

The CDSP provides pre-retirement lump-sum death benefits for the member and enrolled dependents. Failure to enroll children will result in decreased death benefits. This is an employer-provided benefit with no cost to you.

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)

The CHP provides benefits for a wide range of healthcare needs, including routine well-baby visits for your newborn.

☐ **YES, please enroll this dependent in the CHP.**
Your child will also be enrolled in CDSP if eligible.

☐ **NO, do not enroll this dependent in the CHP.**
Your child will be enrolled in CDSP if eligible.

IMPORTANT NOTICE

If you do not enroll your newborn in the CHP at this time, the "Reason for Non-Enrollment" section included in this enrollment form must be completed. Any future request for CHP enrollment for your newborn 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.

(Continued on reverse side)

E 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 HIPAA Certificate of Prior Coverage or similar evidence of prior coverage must be submitted with the request for special enrollment. In the absence of a HIPAA Certificate of Prior Coverage, the individual has the right to 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. *If an individual does these three things, it will be the same as presenting a certificate.*

F 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) ________________

G 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 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.

X ______________________________

Signature of Member — Date

H 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

____

E-mail Address — Daytime Telephone Number