

# NOMINATION OF BENEFIT PLAN REPRESENTATIVE



1. Name and Address of Member/Dependent \_\_\_\_\_  
\_\_\_\_\_
  
2. I hereby appoint the following individual(s) as my Benefit Plan Representative(s). My representative(s) name, address, and telephone number are as follows: \_\_\_\_\_  
\_\_\_\_\_
  
3. I hereby authorize the above individual(s) to obtain plan administration information about me related to the following Concordia Plan(s): (Check all that apply)  
  

<input type="checkbox"/> Concordia Retirement Plan (CRP)	<input type="checkbox"/> Pension Plan for Pastors and Teachers (PPPT)
<input type="checkbox"/> Concordia Disability and Survivor Plan (CDSP)	<input type="checkbox"/> Accident Insurance Program (AIP)
<input type="checkbox"/> Concordia Retirement Savings Plan (CRSP)	
  
4. I understand that this Nomination of Benefit Plan Representative form will allow my designated representative(s) to obtain information related to my benefit plan(s) checked above (i.e., name(s) of designated beneficiaries, retirement account balance, value of death benefits, status of disability claim, amount of disability benefits, etc.). Your Benefit Plan Representative will not be able to make any benefit or membership changes (i.e., change your address or beneficiary, designate new account for electronic funds transfer, change investment options, etc.), or obtain medical information.
  
5. I understand that under no circumstances will Concordia Plan Services staff be allowed to release medical information to my Representative due to privacy and confidentiality reasons. All other plan administration information as outlined in Paragraph 4, above, however, will be released to my designated Representative.
  
6. I understand that if I am a member of the Concordia Health Plan (CHP) that a separate document entitled "Authorization Form for Use or Disclosure of Protected Health Information" will need to be completed in order to have someone assist me in obtaining CHP information. This Authorization form can be found under Resources/Forms at [www.ConcordiaPlans.org](http://www.ConcordiaPlans.org).
  
7. I understand that this Nomination of Benefit Plan Representative form will remain in effect until I am no longer enrolled in the Concordia Plan(s) or my death.
  
8. I understand that I have the right to revoke this form or to nominate a new Benefit Plan Representative at any time. Please contact Concordia Plan Services at 888-927-7526 extension 6704 if you wish to revoke this form or nominate a new Benefit Plan Representative.

\_\_\_\_\_  
*Signature of Plan Member/Dependent*

\_\_\_\_\_  
*Social Security Number of Plan Member/Dependent*

\_\_\_\_\_  
*Today's Date*

### **Return the Completed Authorization To:**

**IF BY MAIL:**

Concordia Plan Services  
Attention: Julie Bruening  
P.O. Box 229007  
St. Louis, MO 63122-9007

**OR**

**IF BY FAX: 314-885-6754**