CONCORDIA PLAN SERVICES
Your LCMS Benefits Partner

Worker Change Report

Duties - Hours - Employment Classification

Changes in a worker's duties, hours, or employment classification can result in a change in compensation, which would affect his/her benefits and participation in the Concordia Plans, and contributions billed to the employer. It is important to report these changes in a timely manner.

1. Use this form to report a change in a worker's:
   a. **Duties and/or hours that results in a compensation change for Concordia Plans' benefit determination.** If the change in duties or hours qualifies a worker for a change in worker's annual compensation, be sure this form is received by Concordia Plan Services (CPS) within 60 days of the change, but no later than within the calendar year of the effective date. If the form is not received in a timely manner, the worker's compensation will not be updated until reported on the Annual Compensation of Participating Workers report; effective January 1st of the next year.
   b. **Hours that result in a change in eligibility for the Concordia Health Plan (CHP).** If the change in hours results in the worker no longer being eligible to participate in the CHP, coverage will normally be terminated at the end of the month in which the worker was employed the required hours to be considered eligible for enrollment in the CHP, unless the change is reported late. Late reporting beyond 30 days of the actual change date will require payment to the CHP through the end of the month in which the written notification is received by CPS. At coverage termination date, the worker will be notified in writing of his/her option to extend his/her CHP coverage on an individual basis.
   c. **Hours that result in worker's eligibility for enrollment in CHP.** Be sure that Section C is also completed, and that this form is received by CPS within 60 days of the change in hours. If this form is timely submitted, CHP coverage is effective on the 1st day of the month following the change in hours.
   d. **Employment Classification for the Concordia Retirement Plan (CRP).** If the change in employment qualifies a worker for enrollment in the CRP Traditional Option or the CRP Account Option, be sure this form is received by CPS within 60 days of the initial effective date. If the form is not received in a timely manner, a "lost income adjustment," retroactive to the effective date of the change and billed through the end of the month in which the change report is received, will be applied and billed to the employer.
2. **DO NOT USE THIS FORM TO REPORT COMPENSATION CHANGES ONLY, OR TO REPORT THAT A WORKER'S HOURS HAVE BEEN CHANGED TO 20 OR LESS.** Compensation changes which are not the result of a change in duties or hours are requested by CPS on the Annual Compensation of Participating Workers report due at the end of each year. If a worker's hours have changed to 20 or less, you should complete the Worker Change Report-Termination/Transfer form as they are considered a terminated worker, and no longer eligible for any benefits under the Concordia Plans.

A EMPLOYER INFORMATION

Employer Name | Employer Number

Address

City | State | Zip Code

B DUTIES - HOURS - EMPLOYMENT CLASSIFICATION

- *Complete one form for each worker*
- *For Effective Date, please indicate the actual date of the change (not a contract date)*

Worker Name (Last, First, Middle Initial) | Social Security Number

CHANGE REQUEST INFORMATION					1	2/3		4	5
		Effective Date				Amount for Housing if:			
Change Request	No Change	Month	Day	Year	Basic Annual Cash Salary	Home Provided (25% of Column 1)	Cash Paid to Worker	Cash Utility Allowance Paid to Worker	Total Salary (Sum of Columns 1, 2/3, 4)
Salary									
Duties/ Job Title					Duties/ Job Title:				
Hours					Hours Worked per Week Changed to:				
Employment Classification					Employment Classification *(Check all that apply)*: ☐ LCMS Rostered ☐ Non-Rostered ☐ Hourly ☐ Salaried				

21049-0216

C CONCORDIA HEALTH PLAN ELECTION INFORMATION

All workers who are employed the required number of hours to be eligible may enroll themselves and any eligible dependents in the CHP if their employer is participating in the plan. (Ask your employer representative if you have any questions about the minimum eligibility requirements for health coverage availability.) Application for CHP enrollment must be made within 60 days of the initial eligibility date, otherwise late enrollment rules apply and coverage may be denied. If your spouse is enrolled in CHP as a worker, they are not eligible to be enrolled as your dependent unless they submit a written request to terminate their worker coverage. If a child is eligible under more than one LCMS worker, he/she can be covered as an eligible family member in the CHP by **only one** worker. Also, if your spouse is in active military service, he/she is not eligible to be enrolled in the CHP as your dependent.

☐ **YES, Enroll me in the CHP.**

Check one class of coverage.

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

If you checked "Yes" and your employer offers Employer Choice, you will be enrolled in the option your employer has elected; If your employer offers Worker Choice, please check your desired plan coverage option (you can only elect an option being offered by your employer):

☐ Option A ☐ Option B ☐ Option C ☐ Option D ☐ Option E ☐ Option HDHP ☐ Option HMO ☐ Option HMO-C ☐ Option HMO-C2

☐ Select 500 ☐ Select 1000 ☐ Choice 1500 ☐ Choice 2000

☐ **NO, I do not wish to enroll in the CHP.**

If you checked "No", please understand that any future request for enrollment for yourself and/or your eligible dependent(s) will be subject to the provisions in effect at the time coverage is requested, which may include having to wait for an open enrollment period or satisfying requirements for special enrollment. If you and/or your eligible dependents do not enroll at this time, please be sure to complete Section E of this form also.

D DEPENDENT INFORMATION

If you are enrolling 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, 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) 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

E REASON FOR NON-ENROLLMENT IN THE CONCORDIA HEALTH PLAN (CHP)

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), 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)
______	______	______	Other reason (CODE 70) ______________________

F 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 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.*

G WORKER SIGNATURE

The information entered on this form is current and correct to the best of my knowledge.

- I understand that any portion of the cost for participation that is my responsibility, according to the provisions of the Concordia Health Plan and the Accident Insurance Program (if applicable), will be obtained from me and remitted along with the portion required from my employer.
- I understand that if I am declining enrollment in the Concordia Health Plan (CHP) for myself and/or any eligible dependent(s) 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 above.
- I agree to provide legal documentation of any dependent's relationship to me upon request. I agree to notify Concordia Plan Services immediately of any change in eligibility of my dependents in the future.

X ______________________________

Signature of Worker — 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

Contact Information:

PO Box 229007
St. Louis, MO 63122-9007

Toll Free: 888-927-7526
St. Louis: 314-965-7580
Fax: 314-996-1127

E-mail: info@ConcordiaPlans.org
Website: ConcordiaPlans.org