Concordia Plan Services
The Lutheran Church—Missouri Synod
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CONCORDIA PLANS

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Critical Illness/Accidental Injury Employer Election

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

A Employer Information

Employer Name (the Employer) _____ Employer Number _____

Mailing Address _____ City _____ State _____ Zip Code _____

B Critical Illness/Accidental Injury

I elect to offer eligible workers the following voluntary benefits effective ____ ____ ____

Please check all that apply.

☐ Critical Illness Insurance

☐ Accidental Injury

C Employer Representative Signature

- I have received and understand the benefit plan(s) documents.
- I understand that this benefit is voluntary and agree to deduct the cost from my workers' payroll.

X _____

Signature of Authorized Employer Representative _____ Date (MM/DD/YYYY) _____

Printed Name of Authorized Employer Representative _____ Title or Office Held _____

Email Address _____ Daytime Phone Number _____

Once the completed form is received and processed your Ministry Engagement Account Manager will reach out to you to coordinate the enrollment process for your members.