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

CONCORDIA PLANS

Concordia Health Plan
Special Enrollment Application Form

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

ONLY CALIFORNIA WORKERS SIGN SECTION L

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

A Instructions

Workers: If you have recently experienced a special enrollment event, please complete Sections B - K and return this form to your employer.

If you are declining enrollment for any eligible dependents, please complete Section I, Reason for Non-Enrollment in the Concordia Health Plan (CHP).

Employers: Please complete Section L and submit the completed form to Concordia Plan Services.

This completed form must be received by Concordia Plan Services within 60 days of the special enrollment event or you and/or your dependents may be required to wait until the next Annual Open Enrollment period to request coverage under the CHP.

B Employer Information

Employer Name _____ Employer ID Number _____

Employer Address _____

City _____ State _____ Zip Code _____ Daytime Phone Number _____

C Worker Information

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

Home Address _____ City _____ State _____ Zip Code _____

Email 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 _____

Country in Which You Hold Citizenship _____

F Concordia Health Plan Election

Unbundled CHP Medical Options: Unbundled CHP Medical Options are for Medical coverage only. Check the box of the Unbundled CHP Medical Option you choose to enroll in:

☐ Healthy Me Copay C*	☐ Healthy Me HSA A*	☐ Whole Health	☐ Select HMO-C Select
☐ Healthy Me Copay D*	☐ Healthy Me HSA B*	☐ Whole Health 1000	☐ HMO-C 2000
☐ Healthy Me Copay E*	☐ Healthy Me HSA C*	☐ Whole Health 2500	
☐ Healthy Me Copay F*	☐ Healthy Me HSA D*	☐ Whole Health 3500	

* If your Employer offers the same medical option through different carriers, select your carrier:

☐ BCBS ☐ Cigna ☐ UMR

Select one Class of Coverage for your Medical coverage:

☐ Self ☐ Self and Spouse ☐ Self and Children ☐ Self, Spouse and Children

☐ I decline enrollment in Unbundled CHP Medical Plan option

F Concordia Health Plan Election (continued)

Unbundled Dental Options: Unbundled Dental Options are for Dental coverage only.
Indicate your enrollment decision by checking the appropriate box below. If you elect to enroll in an Unbundled Dental Option, Please also select the Class of Coverage.

☐ Dental Basic ☐ Dental Plus ☐ Dental Premium ☐ Dental HMO

Select one Class of Coverage for your Medical coverage:

☐ Self Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self, Spouse & Child(ren)

☐ I decline enrollment in the Unbundled Dental Plan option.

Unbundled Vision Options: Unbundled Vision Options are for Vision coverage only.
Indicate your enrollment decision by checking the appropriate box below. If you elect to enroll in an Unbundled Vision Option, Please also select the Class of Coverage.

☐ Vision Basic ☐ Vision Premium

Select one Class of Coverage for your Medical coverage:

☐ Self Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self, Spouse & Child(ren)

☐ I decline enrollment in the Unbundled Vision Plan option.

G Dependent Information

If you are adding 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 under 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. (Note: A Spouse on active military duty is not eligible for CHP enrollment.)

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) IS/ARE TO BE ENROLLED IN THE 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	Date of Birth	Social Security Number

H Important Notice Regarding Special Enrollment in The Concordia Health Plan

Are you requesting coverage for yourself and/or your eligible Dependents because you and/or your Dependent(s) were covered under another health plan and are now no longer eligible for such coverage? ☐ YES ☐ NO

If you check "yes," we must have a copy of the certificate of prior coverage for each individual for whom coverage is being requested. A COBRA extension form CANNOT be accepted as a certificate of prior coverage.

NOTE: If you are unable to promptly obtain a certificate of prior coverage, please submit this application within 60 days of the loss of other coverage and send a copy of the certificate of prior coverage once you have received it. The information submitted will be reviewed to determine special enrollment eligibility in the CHP. If all the requirements are met, eligibility for coverage will be the first day of the calendar month coinciding with or next following the loss of other coverage. This also applies to transferring Workers.

Please provide information regarding the other insurance:

Type of Policy (e.g., medical, dental, etc.)

Name of Insurance Company/Carrier | Policy Holder | Policy Number

Street Address

City | State | Zip Code | Phone Number

Date Other Coverage Began | Date Other Coverage Terminated | Reason Other Coverage Terminated

I Reason for Non-Enrollment in The Concordia Health Plan

Place a check mark on the line next to the reason 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) _____

J 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. *Loss of other coverage.* 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.**

b. *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.

c. *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 annual enrollment period.

d. *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.*

K 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 Plans, will be obtained from me and remitted along with the portion required from my employer. I also agree to provide legal documentation of any dependent's relationship to me upon request.

X _____

Signature of Worker — Date

L Arbitration Agreement

For all California Members enrolling in a Kaiser Option

I understand that any dispute between myself, my heirs, relatives, or associated parties (on the one hand) and Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, the Permanente Medical Group, Inc., Southern California Permanente Medical Group, or their physicians, employees, agents, administrators, contracted health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to my self-funded health plan administered by Kaiser Permanente Insurance Company, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or for premises liability, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a court or jury trial, and instead accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Employer Plan Documents.

The following claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court.
- Claims subject to a Medicare appeals procedure.
- Claims subject to the ERISA claims procedure regulation.
- Claims that cannot be subject to binding arbitration under governing law.

X _____

Signature Required for all Kaiser Permanente Plans — Date (MM/DD/YYYY)

M 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

_____

Email Address — Daytime Phone Number