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

CONCORDIA PLAN SERVICES

Request For Membership Change Form

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

Instructions

Please indicate below what's changing. Check all that apply.

Member Changes:

- ☐ Marital Status Change – Review and complete sections A-E and G-K.
- ☐ Birth/Adoption – Review and complete sections A-E and G-K.
- ☐ Address – Review and complete sections A and K.
- ☐ Termination of the Concordia Health Plan (CHP) for yourself or your dependents – Review and complete sections, A, D, F and K.
- ☐ Termination of Dental Plan for yourself or your dependents - Review and complete sections A, D, F, and K.
- ☐ Termination of Vision Plan for yourself or your dependents - Review and complete sections A, D, F, and K.
- ☐ Other - Please list:_____

Employer Changes:

- ☐ Rostered Status – Review and complete sections A, L, M and O.
- ☐ Salary (applicable only if due to a change in duties or hours), Duties/Job title, Hours or Employment Classification - Review and complete sections A, L, N and O.
- ☐ Other - Please list: _____

Member Section

A Member Information

Title | Last Name | First Name | Middle Initial | Suffix | Previous Last Name

Address | City | State | Zip Code

Last 4 Digits of SSN | Date of Birth (MM/DD/YYYY) | Sex (M/F) | Marital Status | Marital Status Date (MM/DD/YYYY)

Preferred Phone Number | Preferred Email Address | Country in Which You Hold Citizenship

B Dependent Information

Please list your dependents, including your spouse. If listing more dependents than the space provided, attach a sheet giving information as requested below. All eligible dependents listed below will be enrolled in CDSP.

Dependent's Full Name (Last - if different than yours, First, Middle Initial)	Relationship	Sex (M/F)	Date of Birth (MM/DD/YYYY)	Social Security Number	Enroll In: Medical	Dental	Vision
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

C Concordia Health Plan - Waive

If your employer has adopted the Concordia Health Plan (CHP) and you meet the eligibility requirements, you may enroll yourself and your eligible dependents by choosing plan Option and Class of Coverage below and completing Section E. Please contact your employer for information regarding any cost you may incur. **You can *only* elect an Option being offered by your employer.**

If you are declining to enroll in the CHP, please check the box below and complete Section E.

☐ I decline enrollment in the CHP. I have read and understand the Terms of Special Enrollment included on this form.

(Continued on next page)

D Concordia Health Plan - Enroll

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

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

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

☐ I decline enrollment in Unbundled CHP Medical Plan option

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

Select one Class of Coverage for your Dental 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 Vision coverage:
☐ Self Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self, Spouse & Child(ren)

☐ I decline enrollment in the Unbundled Vision Plan option

E Reason for Non-Enrollment in the Concordia Health Plan

Check the box next to the reason you are declining CHP coverage.

- ☐ I am covered under my spouse's or parent's group health plan (coverage by virtue of employment, including military service).
- ☐ I am covered as a dependent under my spouse who is also enrolled in CHP as a worker.
- ☐ I am covered under a military plan (TRICARE) as a retiree, a state mandated plan (e.g., Hawaii), a Medicare Supplemental plan or other government plan (e.g., Medicaid), or another country's mandatory health plan while residing outside the United States.
- ☐ I am covered under the health plan of a non-LCMS employer for whom I am currently working, a former employer's health plan or COBRA coverage.
- ☐ I have 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.
- ☐ I am not eligible for enrollment at this time due to the number of hours worked.
- ☐ I am not enrolling for some other reason _____

(Continued on next page)

F Request to Terminate Coverage

Members may terminate CHP coverage at the end of any month by submitting your request within 30 days of the desired effective date, otherwise coverage will terminate at the end of the month in which CPS receives the written request to terminate coverage.

Please check all that apply and complete the information as requested below.

☐ **I'd like to terminate CHP for myself.**
*Please complete section E and list the termination effective date (MM/DD/YYYY):*_____

☐ **I'd like to terminate CHP for my dependent(s).**
Please complete the information below. If listing more dependents than space provided, attach additional sheet with the requested information.

Reasons for Termination: 1. Active Military Duty 2. Has Full-Time Employment 3. Martial Status Change 4. Other

Name of Dependent	Relationship	Reason for Termination *(Please check one)* 1 2 3 4	Remove From: Medical Dental Vision	Date Event Occured (MM/DD/YYYY)
		☐ ☐ ☐ ☐	☐ ☐ ☐	
		☐ ☐ ☐ ☐	☐ ☐ ☐	
		☐ ☐ ☐ ☐	☐ ☐ ☐	

G Concordia Retirement Plan and Concordia Disability and Survivor Plan

If your employer has adopted the Concordia Retirement Plan (CRP) and the Concordia Disability and Survivor Plan (CDSP) and you meet the eligibility requirements, you will be enrolled in these plans. The plans are funded by your employer to provide you with enhanced financial security into retirement, should you experience a disabling event, or in the event of your or your enrolled dependents death. Therefore, it is important for you to list all your eligible dependents in Section B.

H Personal Spending Accounts

Your employer may offer tax-advantaged accounts to help you pay for out-of-pocket health care costs. These accounts include Limited Purpose Flexible Spending Accounts (LPFSA), Dependent Care Flexible Spending Accounts (DCFSA), Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA). Confirm with your employer which benefits are available to you and visit **ConcordiaPlans.org/enroll** or contact CPS at 888-927-7526 to access the appropriate enrollment form(s).

I Supplemental Life and Accidental Death and Dismemberment Insurance

All full time workers are eligible to enroll in Supplemental Life or Accidental Death and Dismemberment (AD&D) for themselves and qualified dependents if their employer is participating in any of the Concordia Plans and agrees to remit payments. Eligibility requirements for children in both of these coverages follow the same guidelines of the Concordia Disability and Survivor Plan (CDSP). Once you receive a benefit confirmation from Concordia Plans, you may enroll in either or both of these additional plan options. Visit **ConcordiaPlans.org/enroll** or contact CPS at 888-927-7526 to access the appropriate enrollment form(s).

J Accidental Injury and Critical Illness Insurance

Your employer may offer these benefits which can provide lump sum payments for qualified expenses resulting from injury or illness. Confirm with your employer which benefits are available to you, and visit **ConcordiaPlans.org/enroll** or contact CPS at 888-927-7526 to access the appropriable enrollment form(s).

K Worker Signature

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

X _____

Signature of Worker Date (MM/DD/YYYY)

(Continued on next page)

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)

Employer Section

M Employer Information

Employer Name Employer ID Number

Address City State Zip Code

N Minister of Religion

Will the worker's name appear on the Synod's Roster of Ordained and Commissioned Ministers of Religion? ☐ Yes ☐ No

Will the worker be participating in Social Security?..... ☐ Yes ☐ No

☐ As a minister of religion enrolled in the CRP prior to 1982 with participation terminated for no more than 5 years since, and whose self-employed status under Social Security has been in effect since December 31, 1981, the worker requests enrollment in the CRP Traditional Option on the Full Basis.

O Changes to Worker Duties, Hours, Employment Classification Affecting Compensation

Change Request Information					1	2	3	4	5
Change Request	No Change	Effective Date Month	Day	Year	Basic Annual Cash Salary	Calculate 25% Home Provided (25% of Column 1)	Annual Cash Housing Allowance Paid to Worker	Cash Utility Allowance Paid to Worker	Total Salary (Sum of Columns 1, 2, 3, 4)
Salary	☐								
Duties/Job Title	☐				New Job Title:				
Hours	☐				Hours Worked per Week Changed to:				
Employment Classification	☐				Employment: This worker is a/an: ☐ Hourly Worker ☐ Salaried Worker Job Designation: ☐ Faculty ☐ Non-Faculty Pay Frequency: ☐ Bi-Weekly (26) ☐ Monthy (12) ☐ Weekly (52) ☐ Semi-Monthly (24)				

P | 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 (MM/DD/YYYY)

Printed Name of Authorized Employer Representative — Title or Office Held

Email Address — Daytime Phone Number

Terms of Special Enrollment

You and/or your eligible dependents may be able to enroll in the Concordia Health Plan at a later date under the special enrollment provisions if you decline CHP coverage due to coverage in another health plan.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the CHP if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must request enrollment **as soon as possible but no later than 60 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, 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 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.

To request special enrollment or obtain more information, contact Concordia Plan Services Customer Care Team at 888-927-7526.

Member: Please retain this sheet for your records.