



Request For Membership

Change Form

ONLY CALIFORNIA WORKERS SIGN SECTION L

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

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.

D	Concordia Health Plan - Enroll																
Unbundled CHP Medical Options: Unbundled CHP Medical Options are for <i>Medical coverage only</i>. 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. <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Healthy Me Copay C*</td> <td style="width: 33%;">Healthy Me HSA A*</td> <td style="width: 33%;">Whole Health</td> <td style="width: 33%;">Select HMO-C</td> </tr> <tr> <td>Healthy Me Copay D*</td> <td>Healthy Me HSA B*</td> <td>Whole Health 1000</td> <td>Select HMO-C 2000</td> </tr> <tr> <td>Healthy Me Copay E*</td> <td>Healthy Me HSA C*</td> <td>Whole Health 2500</td> <td></td> </tr> <tr> <td>Healthy Me Copay F*</td> <td>Healthy Me HSA D*</td> <td>Whole Health 3500</td> <td></td> </tr> </table> *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		Healthy Me Copay C*	Healthy Me HSA A*	Whole Health	Select HMO-C	Healthy Me Copay D*	Healthy Me HSA B*	Whole Health 1000	Select 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	
Healthy Me Copay C*	Healthy Me HSA A*	Whole Health	Select HMO-C														
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Healthy Me Copay E*	Healthy Me HSA C*	Whole Health 2500															
Healthy Me Copay F*	Healthy Me HSA D*	Whole Health 3500															
E	Reason for Non-Enrollment in the Concordia Health Plan																
<i>Check the box next to the reason you are declining CHP coverage.</i> ☐ 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 <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width: 25%;">Name of Dependent</th> <th rowspan="2" style="width: 10%;">Relationship</th> <th colspan="4" style="width: 25%;">Reason for Termination (Please check one)</th> <th style="width: 15%;">Remove From:</th> <th rowspan="2" style="width: 20%;">Date Event Occured (MM/DD/YYYY)</th> </tr> <tr> <th style="text-align: center;">1</th> <th style="text-align: center;">2</th> <th style="text-align: center;">3</th> <th style="text-align: center;">4</th> <th style="text-align: center;">Medical Dental Vision</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>						Name of Dependent	Relationship	Reason for Termination (Please check one)				Remove From:	Date Event Occured (MM/DD/YYYY)	1	2	3	4	Medical Dental Vision																																
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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 appropriate 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)																																																		

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.		
<i>Member: Please retain this sheet for your records.</i>		