Concordia Plan Services
The Lutheran Church—Missouri Synod
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CONCORDIA PLANS

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ACCIDENTAL INJURY AND CRITICAL ILLNESS ENROLLMENT FORM

Clear

Employee Information

Last Name:_____ First Name:_____ Middle Initial:____

Street Address:_____

City:_____ State:_____ Zip Code: _____

Work Phone:_____ Home Phone:_____ Employee ID #:_____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOR SPOUSE

☐ I am currently married and my date of marriage is: _____

Spouse's Name:_____

Your Coverage Elections (The Summary of Benefits and premium costs can be found at Concordiaplans.org)

Employee-Paid (Voluntary) Critical Illness Insurance - Policy # CL 961488

Please select the people who should be covered and the coverage amount below.

Who you want to Cover	Coverage Amount	Guaranteed Coverage Amount*
☐ Employee	☐ $10,000 ☐ $20,000 ☐ $30,000	☐ $30,000 ☐ Decline Coverage
☐ Spouse	☐ $5,000 ☐ $10,000 ☐ $15,000	☐ $15,000 ☐ Decline Coverage
☐ Children # of covered Children _____	☐ $5,000 ☐ $10,000	All Amounts ☐ Decline Coverage

** This is the Guaranteed Coverage amount. You may choose this amount, or less, without answering medical questions during your enrollment period. All coverage elected during this enrollment period will take effect on the latter of the new plan year or the date the insurance company approves your application.*

Employee-Paid (Voluntary) Accidental Injury Insurance - Policy # AI961567

Please select the people who should be covered and the coverage amount below.

Who you want to Cover	Dependents	Plan	Acceptance
☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Employee + Family	How many children are you covering? _____	☐ Plan 1 ☐ Plan 2	☐ Accept Coverage ☐ Decline Coverage

Employee Election

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 in the programs elected above will be obtained from me through payroll deduction and remitted by my employer and that additional information regarding coverage effective dates and other rules and conditions are described in the program's policy and summary of benefits.

X_____

Signature Date

Please return this form along with other supplementary enrollment forms, if applicable, to your congregational treasurer, business manager, or HR office by the deadline requested by your employer.