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

CONCORDIA PLANS

Nomination of Benefit Plan Representative

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

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

A Member/Dependent Information

Member/Dependent Name

Address

City | State | Zip Code | Phone Number

B Benefit Plan Representative Information

Benefit Plan Representative Name

Address

City | State | Zip Code | Phone Number

If listing more than one benefit plan representative, please use a separate sheet of paper.

C Plan Administration Information

I hereby authorize the above individual(s) to obtain plan administration information about me related to the following Concordia Plan(s): *(Check all that apply)*

- ☐ Concordia Retirement Plan (CRP)
- ☐ Concordia Disability and Survivor Plan (CDSP)
- ☐ Concordia Retirement Savings Plan (CRSP)
- ☐ Accidental Death and Dismemberment Insurance (AD&D)

D Member/Dependent Signature

- I understand that this Nomination of Benefit Plan Representative form will allow my designated representative(s) to obtain information related to my benefit plan(s) checked above (i.e., name(s) of designated beneficiaries, retirement account balance, value of death benefits, status of disability claim, amount of disability benefits, etc.). Your Benefit Plan Representative will not be able to make any benefit or membership changes (i.e., change your address or beneficiary, designate new account for electronic funds transfer, change investment options, etc.), or obtain medical information.
- I understand that under no circumstances will Concordia Plan Services staff be allowed to release medical information to my Representa tive due to privacy and confidentiality reasons. All other plan administration information as indicated in Section C will be released to my designated Representative.
- I understand that if I am a member of the Concordia Health Plan (CHP) that a separate document entitled "Authorization Form for Use or Disclosure of Protected Health Information" will need to be completed in order to have someone assist me in obtaining CHP information. This Authorization form can be found at ***ConcordiaPlans.org***.
- I understand that this Nomination of Benefit Plan Representative form will remain in effect until I am no longer enrolled in the Concordia Plan(s) or my death.
- I understand that I have the right to revoke this form or to nominate a new Benefit Plan Representative at any time. Please contact Concordia Plan Services at 888-927-7526 if you wish to revoke this form or nominate a new Benefit Plan Representative.

X _____

Signature of Member/Dependent | Concordia Plans Member ID | Date (MM/DD/YYY)

Please return the completed Authorization to:
Privacy Officer • Concordia Plan Services
P.O. Box 229007 • St. Louis, MO 63122-9007 • Fax to: 314-996-1127