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

CONCORDIA PLAN SERVICES

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

Enrollment Form

ONLY CALIFORNIA WORKERS SIGN SECTION O

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK
EMPLOYER: PLEASE REVIEW AND COMPLETE ELECTIONS A-C AND P.
WORKER: PLEASE REVIEW AND COMPLETE SECTIONS D-N. (O if in CA)

Clear

A Employment Information

Employer Name _____ Employer ID Number _____

Employer Address _____

Employer City _____ Employer State _____ Employer Zip Code _____ Employer Phone Number _____

Workers Occupation (Be specific - eg write "Elementary Teacher" instead of "Teacher") _____

Scheduled number of hours per week* _____

Full-Time Hire Date (mm/dd/yyyy) _____

Part-Time Hire Date (If applicable mm/dd/yyyy) _____

Is worker hired to work more then 5 consecutive months?* ☐ Yes ☐ No

Does a probationary period apply for benefits? ☐ Yes ☐ No

This worker is an/an: ☐ Hourly worker ☐ Salaried worker

Job designation: ☐ Faculty ☐ Non-faculty

Pay frequency: ☐ Bi-Weekly(26) ☐ Monthly(12) ☐ Weekly(52) ☐ Semi-monthly(24)

* Any worker hired to work more than 20 hours per week AND more than five consecutive months is required to be enrolled in the Concordia Retirement Plan (CRP) and the Concordia Disability & Survivor Plan (CDSP). Any worker who is hired to work the minimum number of hours required for Concordia Health Plan (CHP) benefits, as designated by the employer's ***Declaration of Hours Form*** on file at CPS, AND for more than five consecutive months is eligible to enroll in the CHP. Plan benefits normally begin the first day of the month coinciding with or following a worker's hire date unless a Probationary Period Certification is on file at CPS. A worker's part-time employment period counts toward satisfaction of any probationary period established and on file with CPS.

B Worker Information

☐ Rev. ☐ Mrs. ☐ Dr. ☐ Miss ☐ Mr. ☐ Ms.

Worker's Name (Last, First, Middle Initial) _____ Previous Last Name _____

☐ Junior ☐ Senior ☐ II ☐ III ☐ Other: _____

U.S. Social Security Number _____ Date of Birth(MM/DD/YYYY) _____ ☐ Male ☐ Female Gender

Worker's Address _____ Email Address _____

City _____ State _____ Zip Code _____ Phone _____

C Worker Compensation Information

WORKER COMPENSATION EMPLOYER/PARISH	A Basic Annual Cash Salary	B Calculate 25% Home Provided 25% Of Column A	C Annual Cash Housing Allowance Paid to Worker	D Annual Cash Utility Allowance Paid to Worker	E Annual Total Compensation (A+B+C+D)
Dual Parishes Only--Enter Total Compensation Received					

(Continued on next page)

D Minister of Religion (To be completed by worker)

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

If Yes Complete the following:

Will you be participating in Social Security?..... ☐ Yes ☐ No
Were you placed recently at this employer by the Synod's Board of Assignments?..... ☐ Yes ☐ No

Date of Assignment (MM/DD/YYYY) Date Studies Completed (MM/DD/YYYY) Name of LCMS School From Which You Graduated

Recent graduates assigned by the Synod's Board of Assignments are eligible for early enrollment in the CRP, CDSP and CHP effective the first of any month following the receipt of their assignment and graduation, but not later than their normal effective date. If desired, enter the early enrollment date here: _____

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

E Marital Information (To be completed by worker)

Marital Status

☐ Single – Never Married
☐ Married, Date . . . . . _____
☐ Widowed, Date . . . . . _____
☐ Divorced, Date . . . . . _____

_____
Spouse's Full Name

_____
Spouse's Date of Birth

_____
Spouse's Social Security Number

_____
Spouse's Gender

Enroll In:

Medical	Dental	Vision
☐	☐	☐

F Child(ren) Information (To be completed by worker)

You must complete this section to enroll your eligible child(ren). Failure to enroll your eligible child(ren) will result in decreased or lost benefits. A "child" shall mean your biological, legally adopted, step, and foster child. 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. Please carefully read the following:

Concordia Disability and Survivor Plan (CDSP) - Life Insurance Benefits

Please list your eligible child(ren) as described in 1, 2, and 3 below. Enrolling eligible children provides life insurance protection for them. Please note that there are different eligibility requirements for the CDSP than the Concordia Health Plan. To be eligible under the CDSP, the child must qualify as your dependent for federal income tax purposes (or would qualify as such a dependent, but for exceeding applicable age or earning limits). All elligible children below will be enrolled in the CDSP.

1. Your unmarried child under age 21.
2. Your unmarried child age 21 up to age 26 if a full-time student in an accredited educational institution.
3. Your unmarried child who is 21 or over AND became totally disabled prior to attaining age 21 or became totally disabled while a full-time student at an accredited educational institution (subject to approval).

Note: If both parents are active workers enrolled in the CDSP, each parent should enroll the dependent child(ren) in the CDSP.

Concordia Health Plan (CHP) - Medical, Dental, Prescription, etc., Benefits

To enroll your child(ren), review 4 and 5 below to determine their eligibility as dependents for the CHP.

4. Your child, up to age 26, regardless of student, marital or disabled status.
5. Your unmarried, totally disabled child age 26 and older who became disabled before attaining age 26 (subject to approval).

THE FOLLOWING CHILD(REN) IS/ARE TO BE ENROLLED IN THE CDSP AND/OR 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	Gender	Date of Birth	Social Security Number	Enroll In: Medical	Dental	Vision
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

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G Concordia Health Plan (To be completed by worker)

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 a plan Option and Class of Coverage below and completing Sections E and F. 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 H.

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

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
☐ 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	

* 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 the Unbundled CHP Medical Plan option (Complete Section D, and see Terms of Special enrollment included on this form)

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

☐ Vision Basic ☐ Vision Premium

Select one Class of Coverage for your ***Vision coverage:***

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

☐ I decline enrollment in the Unbundled Vision Plan option

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

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

Select one Class of Coverage for your ***Dental coverage:***

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

☐ I decline enrollment in the Unbundled Dental Plan option.

H Reason for Non-Enrollment in the Concordia Health Plan (To be completed by worker)

Complete only if you are waiving CHP Coverage

☐ I am covered under my spouse's or parent's group health plan (converge 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. Medicid), 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 _____

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I Health Savings Account (To be completed by worker)

HEALTH SAVINGS ACCOUNT (HSA) MAXIMUM CONTRIBUTIONS

2025:

HDHP Single Coverage - $4,350
HDHP Family Coverage - $8,550
Age 55+ Catch-up - $1,000

2026:

HDHP Single Coverage - $4,400
HDHP Family Coverage - $8,750
Age 55+ Catch-up - $1,000

☐ I want to contribute $_____ during this Plan Year to my HSA. I understand this amount will be deducted on a pro rata basis from my paycheck throughout the Plan Year.

☐ I want to participate in the HSA, but I do not want to make any contributions from my paycheck. I only want the employer contributions to be made to my HSA.

J Flexible Spending Account (To be completed by worker)

Medical Flexible Spending Account: 2026 Plan Year Maximum of $3,400.

I want to contribute a total of $_____ during this Plan Year to my Medical Flexible Spending Account. I understand this amount will be deducted from my pay throughout the Plan Year.

Are you or your spouse actively contributing to a Health Savings Account?

☐ No

☐ Yes: Your medical FSA must be limited to the reimbursement of dental and vision expenses until your health plan deductible has been met.

Dependent Care Flexible Spending Account

Plan Year Maximum of $7,500.00 ($3,750.00 if married but filing separate tax returns).

I want to contribute a total of $_____ during this Plan Year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the year.

K 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 E and F.

L 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).

M 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).

N 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)

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O 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)

P Employer 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 at 888-927-7526.

Member: Please retain this sheet for your records.