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

CONCORDIA PLANS

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

Seminary Student Request for Membership Change

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

A Instructions

Instructions for Seminary Students

1. To report a marital status change, or request health plan coverage for your spouse, complete Sections B–F, L, and M. Review and complete Section J, if applicable.
2. To report a dependent child, complete Sections B–E, G, L, and M. Review and complete Section J, if applicable.
3. To terminate your health coverage, complete Sections B–E, H, J, L, and M.
4. To delete dependents no longer eligible or for whom coverage is no longer desired, complete Sections B–E, I, J, L and M.

B Seminary Information

Please check one.

☐ Concordia Seminary
801 Seminary Place
St. Louis, MO 63105
Phone: 314-505-7000
Account SEMSL

☐ Concordia Theological Seminary
6600 North Clinton St.
Fort Wayne, IN 46825
Phone: 260-452-2100
Account SEMFW

C Student Information

Title | Full Name (Last, First, Middle Initial) | Previous Last Name (if applicable) | Social Security Number

Student's Address | City | State | Zip Code | Address Valid Until:

E-mail Address | Daytime Telephone Number

D Marital Status (MM/DD/YYYY)

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

E

Home Telephone Number

Cell Telephone Number

Fax Number

F Request to Enroll Spouse

If you are reporting a marital change or adding coverage for your spouse, please complete this section.

Spouse's Name (Last - if different than yours, First, Middle Initial)

Date of Birth (MM/DD/YYYY) | U.S. Social Security Number | Canada Social Insurance Number

If your spouse is on active duty in any military force of any country, they are not eligible to be enrolled as a dependent.

If eligible, do you desire health coverage for your spouse? ☐ Yes ☐ No*

**If "No," please complete Section J, "Reason for Non-Enrollment in Concordia Health Plan" and review Section K, "Terms of Special Enrollment."*

Spouse's LCMS Employer Name (if applicable) | City | State | Zip Code

Date Spouse's LCMS Employment: Began (MM/DD/YYYY) | Terminated (MM/DD/YYYY) | Is Scheduled to Begin (MM/DD/YYYY)

*If you and/or your spouse were previously enrolled in the Concordia Plans as a **dependent** of a current/previous LCMS worker, please list that worker's name below. (List could include mother, father, foster parents, stepparents, legal guardian, previous spouse, etc., if ever employed by LCMS.)*

Relationship	Last Name	First Name	LCMS Employer	LCMS Employment is:
			Name City/State	☐ Current ☐ Terminated (Yr.)
			Name City/State	☐ Current ☐ Terminated (Yr.)

G Request to Enroll Child(ren)

Your must complete this section to enroll your eligible child(ren). Dependent eligibility for the Concordia Health Plan (CHP) will be considered for :

- your biological, legally adoped, step, and foster child(ren)
- your child up to age 26, regardless of student, marital or disabled status (you may be required to submit a birth certificate or legal documentation)
- your unmarried totally disabled child(ren) who became disabled before attaining age 26 (subject to approval and you may be required to submit a birth certificate or legal documentation)21050
- in certain situations, grandchild(ren) or step-grandchild(ren). Contact Concordia Plan Services at 888-927-7526 for information.

THE FOLLOWING CHILD(REN) IS/ARE TO BE ENROLLED IN THE CHP:

- *If adding a foster child or legally adopted child, please include copies of legal documentation.*
- *If listing more children than space provided, attach sheet giving information as requested below.*
- *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.*

Dependent's Full Name	Relationship	Date of Birth	Social Security Number

H Request to Terminate Student Health Coverage

☐ Please terminate my participation in the Concordia Health Plan. I understand that if this written request for termination is received by Concordia Plan Services (CPS) more than 30 days after the requested termination date, my coverage will terminate at the end of the month in which CPS receives the form and contributions will be due through the date.

_____
Requested Termination Date

I Request to Terminate Dependent Coverage

☐ Please terminate the participation of the Dependents listed below in the Concordia Health Plan. I understand that if this written request for termination is received by Concordia Plan Services (CPS) more than 30 days after the dependent is no longer eligible or the requested termination date, coverage will terminate at the end of the month in which CPS receives the form and contributions will be due through that date. Sections J, L, and M must also be completed.

Reasons for Termination:
1. Active Military Duty 2. Has Full-time Employment 3. Marriage 4. Other

Name of Dependent	Relationship	Reason for Termination *(Please check one.)*	Remove from: CHP	Remove from: CDSP	Date Event Occurred (MM/DD/YYYY)
		☐ 1 ☐ 2 ☐ 3 ☐ 4 _____	☐	☐	
		☐ 1 ☐ 2 ☐ 3 ☐ 4 _____	☐	☐	
		☐ 1 ☐ 2 ☐ 3 ☐ 4 _____	☐	☐	
		☐ 1 ☐ 2 ☐ 3 ☐ 4 _____	☐	☐	

J Reason for Non-Enrollment in the Concordia Health Plan

Place a check mark on the line next to the reason if you, your spouse, or dependent child(ren) are declining CHP coverage.

Student	Dependent Spouse	Dependent Child(ren)	
			Covered under spouse's or parent's group health plan (coverage by virtue of employment, including military service). (CODE 51)
			Covered as a dependent under my spouse who is also enrolled in CHP as a worker. (CODE 72)
			Covered under a military plan (TRICARE) as a retiree, a state mandated health plan (e.g., Hawaii), or another country's mandatory health plan while residing outside the United States. (CODE 52)
			Covered under a Medicare supplemental plan or other government plan (e.g., Medicaid).(CODE 63)
			Covered under a former employer's health plan or COBRA plan. (CODE 64)
			Covered under non-LCMS employer's health plan. (CODE 65)
			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. (CODE 73)
NA			Other reason (CODE 70) _____

K Terms of Special Enrollment

Special Enrollment: Students and/or their eligible dependent(s), who previously declined CHP coverage due to other coverage in another health plan, may be eligible to enroll in the CHP at a later date under the special enrollment provisions if they are eligible for coverage and the following conditions are met. Application for special enrollment in the CHP must be received by Concordia Plan Services **as soon as possible but no later than 60 days** after the event (i.e., loss of other health coverage or the reason for requesting CHP enrollment).

a. *Statement of reason for declining coverage.* The student must provide a statement at the time coverage is declined indicating the reason for declining coverage. **Any break in covered periods must be less than 63 days.**

b. *Loss of other coverage.* To be eligible for the special enrollment period, coverage must be lost due to a loss of eligibility for the other coverage or the employer contributions toward the other coverage must have ended. Loss of eligibility includes a loss of coverage due to divorce, legal separation, death, termination of employment, or reduction in hours of employment. Loss of coverage does not include a loss due to failure of the participant to pay premiums for any reason or termination of the other coverage for cause. **Any break in covered periods must be less than 63 days.**

c. *Children's Health Insurance Program (CHIP) Reauthorization Act of 2009.* A student (or dependent) who is eligible, but not enrolled for coverage, may enroll for coverage if: (1) The student (or dependent) is covered under a state Medicaid or state children's health insurance plan and coverage is terminated as the result of the loss of eligibility for Medicaid or state children's health insurance coverage; or (2) The student (or dependent) becomes eligible for premium assistance to purchase coverage under the group health plan provided by the applicable state Medicaid or state children's health insurance plan; and (3) The student requests coverage **no later than 60 days** after the date eligibility is lost or the date the student (or dependent) is determined to be eligible for state premium assistance.

d. *New dependent due to marriage, birth, adoption, or placement for adoption.* 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/or 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.

e. *Certification.* A certificate of prior coverage or similar evidence of prior coverage must be submitted with the request for special enrollment. In the absence of a certificate of prior coverage, the individual has the right to demonstrate prior coverage by (1) attesting to such coverage, (2) providing corroborating evidence (e.g., a doctor's bill or pay stub showing payroll deduction), and (3) cooperating with the plan to demonstrate coverage. *If an individual does these three things, it will be the same as presenting a certificate of prior coverage.*

L Student Signature

The information entered on this form by me is current and correct to the best of my knowledge. I authorize the Seminary to obtain the cost required by me (if applicable), according to the Plan provisions, for my participation in the Concordia Health Plan and to remit any such payment due to Concordia Plan Services. I also agree to provide legal documentation of any dependent's relationship to me upon request. I agree to notify Concordia Plan Services immediately if any of my dependents' eligibility changes in the future.

If I requested to terminate the CHP coverage for myself or any of my dependents, I understand that any future request for enrollment in the Concordia Health Plan (CHP) will be delayed until an open enrollment period is provided, unless I and/or my eligible dependent(s) become eligible for "special enrollment" as outlined in Section K, "Terms of Special Enrollment."

X _____

Signature of Student | Date

M Seminary Representative Signature

The student information entered on this form is current and correct to the best of our knowledge. We agree to obtain from the student the cost required (if applicable), according to the Plan provisions, for the student's participation in the Concordia Health Plan and to remit any amount due directly to Concordia Plan Services.

X _____

Signature of Authorized Seminary Representative | Date

_____

Printed Name of Authorized Seminary Representative | Title or Office Held

_____

E-mail Address | Daytime Telephone Number