Concordia Plan Services
The Lutheran Church—Missouri Synod
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CONCORDIA PLAN SERVICES

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Concordia Health Plan
2020 Annual Open Enrollment

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK Clear

A Worker Information

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

Home Address | City | State | Zip Code

Email Address | Daytime Phone Number

B Concordia Medical, Dental, and Vision Plan Options

Your employer has determined your Concordia Health Plan (CHP) coverage Option(s) and ***you can only elect an Option that is being offered by your employer.*** Check with your employer representative if you have questions about the 2020 CHP Option(s) being offered to you. ***To reset your elections click*** Clear

Bundled CHP Options: Bundled CHP Options include medical, dental and vision coverage. Check the box of the Bundled CHP Option you choose to enroll in:

☐ Option A ☐ Option B ☐ Option C
☐ Option D ☐ Option E ☐ Option HDHP
☐ Select 500 ☐ Select 1000 ☐ Choice 1500
☐ Choice 2000 ☐ Choice 3000

Select one Class of Coverage for your Medical, Dental and Vision coverage:
☐ Self Only ☐ Self and Spouse ☐ Self and Children ☐ Self, Spouse and Children
☐ I decline enrollment in the CHP Bundled Medical Plan option (Complete Section D, and see 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 A ☐ Whole Health
☐ Healthy Me B ☐ Whole Health 1000
☐ Healthy Me C ☐ Whole Health 2000

Select one Class of Coverage for your ***Medical coverage:***
☐ Self Only ☐ 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 Dental Options: Unbundled Dental Options are for ***Dental coverage only.*** Check the box of the Unbundled Dental Option you choose to enroll in:

☐ Dental A ☐ Dental B

Select one Class of Coverage for your ***Dental coverage:***
☐ Self Only ☐ Self and Spouse ☐ Self and Children ☐ Self, Spouse and Children
☐ I decline enrollment in the Unbundled Dental Plan option.

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 A ☐ Vision B

Select one Class of Coverage for your ***Vision coverage:***
☐ Self Only ☐ Self and Spouse ☐ Self and Children ☐ Self, Spouse and Children
☐ I decline enrollment in the Unbundled Vision Plan option.

(Continued on next page)

C Dependent Information

Please list your dependents, including your spouse that you are enrolling in any of the medical, dental, and/or vision plan options elected in Section B. If listing more dependents than space provided, attach a sheet giving information as requested below.

If you have enrolled in a Bundled CHP Option, you only need to check the Medical box for those dependents you wish to enroll. They will automatically be enrolled with dental and vision coverage.

If you have enrolled in an Unbundled CHP Medical, Dental, and/or vision option(s), you need to check all the plans that you wish each dependent to be enrolled in. You can elect different plan enrollments for each dependent.

Dependent's Full Name	Relationship	Gender	Date of Birth	Social Security Number	Enroll In: Medical	Dental	Vision
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

D Reason for Non-Enrollment in the Concordia Health Plan

- ☐ 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 _____

E Supplemental Life and Accidental Death and Dismemberment

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. To access more information and application forms, visit www.concordiaplans.org/life-loss or contact Concordia Plans at 888-927-7526.

F Worker Signature

The information entered on this form is current and correct to the best of my knowledge.

X _____

Signature of Worker | Personal Email Address (required field) | Date

G Employer Information and Signature

As the employer representative, I acknowledge that the information entered on this form for this worker is complete and accurate to the best of my knowledge.

_____

Employer Name | Employer ID

_____

Employer Address

_____

City | State | Zip Code | Daytime Phone Number

_____

Printed Name of Authorized Employer Representative | Title of Office Held

X _____

Signature of Authorized Employer Representative | Date

Workers should return this form to their congregational treasurer, business manager, or HR office by the requested deadline.
Employers must have enrollment information to Concordia Plan Services by November 15, 2019

Please make sure that all requested information is provided on this form;
missing information will delay the processing of the application or may result in the application being denied.

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.