

Enrollment Form

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A	Employer Information			
Employer Name		Employer ID Number		
Address				
City	State	Zip Code	Employer Phone Number	
Employer District Affiliation	Employer E-mail Address		Employer Fax Phone Number	
Worker's Occupation	Is worker hired to work more than 5 consecutive months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scheduled No. of Hours per Week*	Is this worker deployed (works at location other than employer)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Full-Time Hire Date (MM/DD/YYYY)	Does a probationary period apply for benefits?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Part-Time Hire Date (MM/DD/YYYY)	This worker is an/a:		<input type="checkbox"/> Hourly worker	<input type="checkbox"/> Salaried worker
<p>*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 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.</p>				
B	Worker Information			
<input type="checkbox"/> Rev. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss		<input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/> II <input type="checkbox"/> III		
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. Worker's Name (Last, First, Middle Initial)		Previous Last Name <input type="checkbox"/> Other: _____		
C	U.S. Social Security Number	Canada Social Insurance Number	D	E Gender
			Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
F	Worker's Address			
Worker's Address				
City		State	Zip Code	
G	Marital Status (MM/DD/YYYY)		H	
<input type="checkbox"/> Single – Never Married <input type="checkbox"/> Married, Date <input type="checkbox"/> Widowed, Date <input type="checkbox"/> Divorced, Date <input type="checkbox"/> Legally Separated, Date _____		Home Phone Number _____ Cell Phone Number _____ Fax Phone Number _____ E-mail Address _____ Country in Which You Hold Citizenship _____		
I	Spouse Information			
<i>If you are married, please complete this section.</i>				
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	
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)	

J Previous Enrollment Information

If you and/or your spouse were previously enrolled in the Concordia Plans as a worker or **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	<input type="checkbox"/> Current <input type="checkbox"/> Terminated (Yr.)
			Name City/State	<input type="checkbox"/> Current <input type="checkbox"/> Terminated (Yr.)

K Child(ren) Information

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).

1. Your unmarried child under age 21.
2. Your unmarried child age 21 up to age 27 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. You may be required to submit a birth certificate or legal documentation.

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 CHP CDSP
_____					<input type="checkbox"/> <input type="checkbox"/>
_____					<input type="checkbox"/> <input type="checkbox"/>
_____					<input type="checkbox"/> <input type="checkbox"/>
_____					<input type="checkbox"/> <input type="checkbox"/>
_____					<input type="checkbox"/> <input type="checkbox"/>
_____					<input type="checkbox"/> <input type="checkbox"/>

L Concordia Health Plan Enrollment

All eligible workers of a participating employer may enroll themselves and any eligible dependents in the Concordia Health Plan (CHP). (Ask your employer representative if you have any questions about the minimum eligibility requirements for health coverage.) Application for CHP enrollment must be made within 60 days of the initial eligibility date, otherwise late enrollment rules apply and coverage may be denied. In addition to any eligible children, your spouse is eligible to be enrolled as your dependent regardless of his/her eligibility to be enrolled in the CHP as a worker. If your spouse is in active military service, he/she is not eligible to be enrolled in the CHP as your dependent.

L**Concordia Health Plan Enrollment (Cont.)****IMPORTANT NOTICE**

If you and/or your eligible spouse and/or eligible children do not enroll at this time, the "Reason for Non-Enrollment", Section M below, must be completed. Any future request for CHP enrollment for you and/or your eligible dependent(s) will be subject to the plan provisions in effect at the time coverage is requested, which may include having to wait for an open enrollment period or satisfying requirements for a special enrollment date.

 YES, I wish to enroll in the CHP.

Check one class of coverage.

Self Only (Class 1) Self and Spouse (Class 2) Self and Children (Class 3) Self, Spouse, and Children (Class 4)

If you checked "Yes" and your employer offers Employer Choice, you will be enrolled in the option your employer has elected; If your employer offers Worker Choice, please check your desired plan coverage option (you can only elect an option being offered by your employer):

Option A Option B Option C Option D Option E Option HDHP Option HMO Option HMO-C Option HMO-C2
 Select 500 Select 1000 Choice 1500 Choice 2000

 NO, I do not wish to enroll in the CHP.

Check "No" if you are declining coverage for any reason including: not eligible to enroll in the CHP or if you electing to enroll as a dependent under your spouse who also has coverage in the CHP. Be sure to select applicable reason for declining coverage in Section M.

M**Reason For Non-Enrollment In The Concordia Health Plan**

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

Worker	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)
_____	_____	_____	Not eligible for enrollment at this time due to the number of hours worked. (CODE 55)
_____	_____	_____	Other reason (CODE 70) _____

N**Terms Of Special Enrollment**

Special Enrollment: Workers 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).

- Statement of reason for declining coverage.* The worker 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.**
- COBRA coverage exhausted.* If coverage was declined for a worker and/or any dependent(s) because the other coverage was COBRA continuation coverage, the COBRA continuation coverage must be exhausted before the special enrollment will be available. **Any break in covered periods must be less than 63 days.**
- Loss of other coverage.* If the other coverage that applied to the worker and/or any dependent(s) when enrollment was declined was not COBRA continuation coverage, then to be eligible for the special enrollment period, the 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.**
- Children's Health Insurance Program (CHIP) Reauthorization Act of 2009.* A worker (or dependent) who is eligible, but not enrolled for coverage, may enroll for coverage if: (1) The worker (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 worker (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 worker requests coverage **no later than 60 days** after the date eligibility is lost or the date the worker (or dependent) is determined to be eligible for state premium assistance.
- 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.
- Certification.* A certificate of prior coverage or similar evidence of prior coverage must be submitted with the request for special enrollment. In lieu of a certificate of prior coverage, the individual may 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. *An individual who meets all three criteria will be treated as providing certification of prior coverage.*

O Accident Insurance Program

All full-time workers are eligible to enroll if their employer is participating in any of the Concordia Plans and agrees to remit payments. The employer is not required to pay any portion of the cost of this coverage, although they may do so if they desire. Please refer to **ConcordiaPlans.org**, Disability and Survivor, Accident Insurance for further information and rates. Accident Insurance Program (AIP) eligibility requirements for children follow the same guidelines as the Concordia Disability and Survivor Plan (CDSP).

INSURANCE AMOUNT	INDIVIDUAL PLAN	FAMILY PLAN
\$ 300,000	<input type="checkbox"/> 1J	<input type="checkbox"/> 2J
\$ 250,000	<input type="checkbox"/> 1I	<input type="checkbox"/> 2I
\$ 200,000	<input type="checkbox"/> 1H	<input type="checkbox"/> 2H
\$ 175,000	<input type="checkbox"/> 1G	<input type="checkbox"/> 2G
\$ 150,000	<input type="checkbox"/> 1F	<input type="checkbox"/> 2F
\$ 125,000	<input type="checkbox"/> 1E	<input type="checkbox"/> 2E
\$ 100,000	<input type="checkbox"/> 1D	<input type="checkbox"/> 2D
\$ 75,000	<input type="checkbox"/> 1C	<input type="checkbox"/> 2C
\$ 50,000	<input type="checkbox"/> 1B	<input type="checkbox"/> 2B
\$ 25,000	<input type="checkbox"/> 1A	<input type="checkbox"/> 2A

- YES** Enroll me in the Plan selected.
Check one box to the right.
- NO** Do not enroll me.

P Ministers Of Religion

Were you placed recently at this employer by the Synod's Board of Assignments? Yes No
If yes, insert the information requested below.

Date of Assignment _____ Date Studies Completed _____

Name of LCMS School From Which You Graduated _____

R Self-Employment Social Security Tax

Do you pay, or will you be paying "Self-Employed" Social Security tax? Yes No

S Early Enrollment Date for Assigned Worker

To be completed by the employer representative.

Q LCMS Lutheran Annual Listing

Check the listing under which your name appears or will appear in the LCMS Lutheran Annual. If this does not apply to you, please check the "None of the Above" box.

Ordained Minister of Religion—Pastor

Commissioned Minister of Religion (select one below)

Teacher Director of Family Life Ministry

DCE Director of Christian Outreach

Deaconess Director of Parish Music

Parish Assistant Lay Minister

None of the Above

This section is applicable only if the worker is a new graduate assigned by the Synod's Board of Assignments. Such a worker will normally be enrolled the first day of the month after reporting for work at the employer, as are other workers. However, the employer may request that such a worker be enrolled at an earlier date, as permitted within the plan provisions for newly assigned graduates. The earlier date of enrollment, if requested by the employer, will be the first day of any month following the date all academic requirements for graduation were completed and the graduate was assigned. However, the date cannot be later than the first day of the month following the date that the individual reports for work.

If an early enrollment date is desired, enter the month enrollment is to be effective: _____

T Concordia Retirement Plan Participation Basis

Ordained and commissioned ministers of religion (1) who were participating in the Concordia Retirement Plan (CRP) on December 31, 1981; (2) who were deemed to be a self-employed person under Social Security laws and whose self-employed status did not subsequently terminate; and (3) whose participation in the CRP as a worker has not subsequently terminated for a period of more than five years may be eligible to participate in the CRP on a FULL BASIS. Any worker enrolled in the CRP on or after January 1, 1982 is not eligible for the FULL basis.

Check here if this option is available to you and you wish to elect it.

U Worker Compensation Information

To be completed by the employer representative.

The compensation information you provide will be used as the basis for Retirement, Disability and Death Benefits for this worker, and for billing purposes for the CRP and CDSP. Carefully follow the directions on pages 5-6. If your congregation is part of a dual parish, report compensation information received from each congregation separately as shown in examples on the last pages of this form.

		B	C/D		E	F
Employer Account Number (if known)	LCMS Employer	Annual Cash Salary Paid Over 12-Month Period	Annual Amount for Housing if		Annual Cash Utility Allowance Paid to Worker	Total Compensation Column B-C/D-E
	Name:		Home Provided (25% of Column B)	Cash Paid to Worker		
	City/State:					
	Name:					
	City State:					
Dual Parishes Only—Enter Total Compensation Received						

V Worker Signature

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

- I authorize my employer to obtain any portion of the cost required from me, according to the Plan provisions, for my participation in the Concordia Health Plan (CHP) or the Accident Insurance Program (if applicable), and to remit such portion along with the portion required of my employer to Concordia Plan Services.
- I agree to provide legal documentation of any dependent’s relationship to me upon request. I also agree to notify Concordia Plan Services immediately of any eligibility changes for my dependents in the future.
- If I decline or later request to terminate the CHP coverage for myself or any of my dependents, I understand that any future request for enrollment in the 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 N, “Terms of Special Enrollment.”

X _____
Signature of Worker Date

W Employer Representative 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

Printed Name of Authorized Employer Representative Title or Office Held

X Employer’s Instructions For Entering Compensation Information

COLUMN B – BASIC ANNUAL CASH SALARY. Enter the basic annual cash salary in effect on **the date of hire**.

DO include: Amounts withheld through salary reduction for a 403(b) annuity, contract, or plan; including the Concordia Retirement Savings Plan
Amounts withheld through salary reduction for a Cafeteria Plan or Section 125 plan

DO NOT include: A car or travel allowance
A Social Security or FICA allowance
Salary adjustments that may be given after January 1
A cash housing or utility allowance (these will be reported in Columns D and E)
Amounts paid to a Minister of Religion for the difference between the Regular and Full Basis rates for the CRP

- If you have workers who are paid on an hourly basis, their annual salaries can be determined by multiplying their hourly wage by the number of hours it is estimated they will work during a 12-month period.
- If you have a worker receiving compensation from two or more congregations, only one form is required. (List the compensation being paid by each congregation; see examples on the reverse side of this sheet.) If your Dual Parish status has changed, request and submit a “Designation of Contact Congregation” form.
- If you have workers who earn their entire annualized compensation over a compressed work year, (e.g. teachers), please report the compensation they earn for the entire year, regardless of how it is paid out.

COLUMN C – HOME PROVIDED. If a parsonage or other type of employer-owned housing is provided for the worker to live in as his/her primary residence and the worker does not pay rent, enter 25% of Column B in Column C for the employer that owns the residence. (Please note that if a husband and wife are both enrolled and residing in a home provided by the same employer, an amount should be entered in this column only for the individual whose compensation agreement with the employer includes the housing provision.) If no employer-owned housing is provided for the worker, leave this column blank. If there is a dual parish relationship, please use the examples cited below to determine whether and how each parish should report an amount for provided housing.

COLUMN D – CASH HOUSING ALLOWANCE. If a CASH allowance is paid directly to a worker by the employer for housing, enter the annual amount in this column. (It is possible that a worker is provided free residence and paid a cash housing allowance. In that case, figures should be entered in both Column C and Column D.) If no cash housing allowance is paid to the worker, leave this column blank.

COLUMN E – CASH UTILITY ALLOWANCE. If a CASH allowance is paid directly to the worker for utilities, enter the annual amount in this column. (DO NOT include utility payments made directly to the utility company by the employer). If no cash utility allowance is paid to the worker, leave this column blank.

COLUMN F – TOTAL COMPENSATION. Add columns B, C, D, and E and enter the total in this column. A FIGURE MUST BE ENTERED in COLUMN F because payments for participation in the Concordia Retirement Plan and Concordia Disability and Survivor Plan are based on this amount, as are the payments of many benefits.

Examples for Multiple Parish Compensation Reporting

Example 1 – Both Congregations Provide a Cash Housing Allowance

	A	B	C	D	E	F
Worker's Name and Identification Number	Hours Worked per Week	2016 Basic Annual Cash Salary	Home Provided 25% of Column B	Annual Cash Housing Allowance	Annual Cash Utility Allowance Paid to Worker	2015 Total Salary B+C+D+E
JONES, ROBERT C.						
St. John	20	17,000		4,500	1,200	22,700
Trinity	20	15,000		3,500	1,200	19,700
		32,000		8,000	2,400	42,400

Example 2 – Only One Congregation Provides a Home

	A	B	C	D	E	F
Worker's Name and Identification Number	Hours Worked per Week	2016 Basic Annual Cash Salary	Home Provided 25% of Column B	Annual Cash Housing Allowance	Annual Cash Utility Allowance Paid to Worker	2015 Total Salary B+C+D+E
SMITH, DAVID A.						
Grace	35	25,000	6,250	900	900	33,050
Immanuel	15	10,000	0	0	0	10,000
		35,000	6,250	900	900	43,050

Example 3 – Congregations Share Ownership of Residence, or One Employer Owns Residence but the Other Employer Shares Expenses Such as Mortgage Payments, Repairs, Taxes, or Maintenance.

	A	B	C	D	E	F
Worker's Name and Identification Number	Hours Worked per Week	2016 Basic Annual Cash Salary	Home Provided 25% of Column B	Annual Cash Housing Allowance	Annual Cash Utility Allowance Paid to Worker	2015 Total Salary B+C+D+E
MEYER, JAMES P.						
Christ	20	17,000	4,250		900	22,150
Good Shepherd	20	15,000	3,750		900	19,650
		32,000	8,000		1,800	41,800

Example 4 – One Parish Owns Home but Second Parish Pays a Cash Housing Allowance Directly to Worker

	A	B	C	D	E	F
Worker's Name and Identification Number	Hours Worked per Week	2016 Basic Annual Cash Salary	Home Provided 25% of Column B	Annual Cash Housing Allowance	Annual Cash Utility Allowance Paid to Worker	2015 Total Salary B+C+D+E
SCHMIDT, THOMAS C.						
Holy Cross	20	17,000	4,250		1,000	22,250
Zion	20	16,000		900	1,000	17,900
		33,000	4,250	900	2,000	40,150

Note: If you have dual income for a worker, the information is needed to determine which employer is providing housing allowance and to ensure correct billing continues, if the dual arrangement ends. The worker's employing organization (primary) must officially designate the allowance as a housing allowance before paying it to the minister.

**Concordia Disability & Survivor Plan
 and Accident Insurance Program
 Beneficiary Designation Form - Active Worker**

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A	Instructions	
	<ol style="list-style-type: none"> 1. If you participate in the Concordia Disability and Survivor Plan and/or the Accident Insurance Program, a lump-sum death benefit is provided in the event of your death. Use this form to indicate the person or entity you wish to receive the benefit. 2. You can change or revoke this designation at any time by sending in a new, properly completed form. 3. Your beneficiaries do not have to be dependents or relatives. You can name any person, a trust, or an institution except you cannot legally designate your own employer as a beneficiary. However, the same result can be achieved by designating “Estate” and providing a bequest to the employer via your Will. You can designate any other organization having a legal entity within the Synod (example: a congregational pastor can designate The Lutheran Church—Missouri Synod Foundation as a beneficiary). To designate a trust as a beneficiary, please list the name and date of the trust, and the name of the trustee(s). 4. If you are naming a trust as your beneficiary, please note the name of the trust under [Name] and write “Trust” under [Relationship] and “Not applicable” for [Social Security Number]. A Tax Identification Number (TIN) and a signed copy of the trust is needed at the time benefits are payable. 5. When naming a person as a beneficiary, list the person’s full name, Social Security number, their relationship to you, and the person’s home address. A married woman must be designated by her own given name (example: Mrs. Mary Doe), not listed as “Mrs. John Doe.” 6. It is normally recommended that minor children not be listed as beneficiaries since payments cannot be made to minors. If your beneficiary is a minor at the time of your death, guardian papers for the estate and/or property of the minor child must be secured by the surviving parent or the child’s guardian and a copy submitted to Concordia Plan Services in order to receive the death benefit(s). 7. If no beneficiary is named, or if no named beneficiary survives you, the lump-sum death benefit will be paid to: <ol style="list-style-type: none"> a. your lawful spouse, if living; otherwise to b. your natural or legally adopted child(ren) in equal shares, if living; otherwise to c. your parents in equal shares, if living; otherwise to d. the personal representative of your estate. 	
B	Primary Beneficiaries	C Secondary Beneficiaries
	<ul style="list-style-type: none"> • Your Primary Beneficiary(ies) is the individual(s), institution(s) and/or trust(s) you name to receive the lump-sum death benefit payable upon your death. • If you name more than one Primary Beneficiary, your death benefit will be divided among the Primary Beneficiaries you name in the proportions you specify. If no proportions are specified, the benefit will be divided equally among the Primary Beneficiaries. • If one or more of your Primary Beneficiaries should die before you, the death benefit will be divided proportionately among the surviving Primary Beneficiaries. • If all of your Primary Beneficiaries die before you, the death benefit will be paid to your Secondary Beneficiaries. 	<ul style="list-style-type: none"> • Your Secondary Beneficiary(ies) is the individual(s), institution(s), and/or trust(s) you name to receive the lump-sum death benefit payable upon your death if none of your Primary Beneficiaries are alive at the time of your death. <p>If none of your Primary Beneficiaries survives you, then:</p> <ul style="list-style-type: none"> • Your Secondary Beneficiaries will receive the death benefit upon your death. • The death benefit will be divided among your Secondary Beneficiaries in the proportions you specify. If no proportions are specified, the death benefit will be divided equally among the Secondary Beneficiaries. • If one or more of your Secondary Beneficiaries dies before you, the death benefit will be divided proportionately among your remaining Secondary Beneficiaries. If all of your Secondary Beneficiaries die before you, the death benefit will be paid as stated in Number 7 above.

**Concordia Disability & Survivor Plan and Accident Insurance Program
Beneficiary Designation Form - Active Worker**

C Participant Information

After reading the instructions on the reverse side, please print clearly and complete all information.

Title	Name (Last, First, Middle Initial)	Social Security Number
Home Address: Street	City	State Zip Code Home Phone Number
Email Address	Cell Phone Number	Work Phone Number
Employer Name	City	State Zip Code Phone Number

D Plan Designation

Please check the appropriate box if this designation is for:

- ONLY** Concordia Disability and Survivor Plan **ONLY** Accident Insurance Program
 BOTH Concordia Disability and Survivor Plan AND Accident Insurance Program

E Beneficiary Designation

I hereby make the following designation for the distribution of any benefit payable at the time of my death:

Primary Beneficiary(ies): [First in order to receive the death benefit]

Name	Social Security Number	Relationship	
Address	City	State	Zip Code
Name	Social Security Number	Relationship	
Address	City	State	Zip Code

MUST BE COMPLETED
+ % Allocation
+ % Allocation
Total Primary Beneficiary Allocation Must Equal: 100%

Secondary Beneficiary(ies): [Recipient of death benefit if the Primary Beneficiary(ies) pre-deceases you]

Name	Social Security Number	Relationship	
Address	City	State	Zip Code
Name	Social Security Number	Relationship	
Address	City	State	Zip Code
Name	Social Security Number	Relationship	
Address	City	State	Zip Code

MUST BE COMPLETED
+ % Allocation
+ % Allocation
+ % Allocation
Total Secondary Beneficiary Allocation Must Equal: 100%

If you need more room to designate beneficiaries, please attach a separate sheet with your name, Social Security number, signature, date, the words "CDSP/AIP," and your additional Primary and/or Secondary Beneficiaries.

F Participant Signature

I understand that this beneficiary designation will become effective upon receipt of this Beneficiary Designation form by Concordia Plan Services. It will remain in effect until either (1) a new Beneficiary Designation form signed by me is received by Concordia Plan Services, or (2) my membership in the Concordia Disability and Survivor Plan and/or Accident Insurance Program is terminated. I further understand that in the event of a dispute as to the eligible beneficiary(ies) at the time of my death, the determination of Concordia Plan Services will be final and conclusive. I do hereby, for myself, my beneficiaries, heirs, executors, and administrators, release Concordia Plan Services from any and all liability for any and all payments that may be made as a result of and in accordance with this Beneficiary Designation form.

X _____
Signature of Participant Date

Mail this form to: Concordia Plan Services • P.O. Box 229007 • St. Louis, MO 63122-9007 • Fax 314-996-1127



**Concordia Retirement Savings Plan
 Salary Deferral Agreement**

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A Participant Information

Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)	Social Security Number
Email Address	Phone Number	

Under IRS 403(b) regulations, employers have administrative and compliance responsibilities that require the following information:

- Have you contributed to any 401(k), 403(b) or SEP providers other than the Concordia Retirement Savings Plan during the current calendar year? Yes No
 If yes, please list total amount contributed to any 401(k), 403(b) or SEP provider(s) during the current calendar year (exclude Concordia Retirement Savings Plan contributions with current employer) \$ _____.
- If you have authorized contributions to any other 403(b) provider between 1/1/2005 and 12/31/2008, please list provider name(s):

- Do you have any outstanding 403(b) loans with the Concordia Retirement Savings Plan or another provider? Yes No
 If yes, do you need payroll deductions set up to repay the loan? Yes No
- Have you taken a 403(b) Hardship Withdrawal in the past 6 months? Yes No
 If yes, what was the date of the withdrawal? _____

Note: Salary deferrals cannot begin until six months after the hardship withdrawal date.

B Types of Contributions and Contribution Limits

- You may elect to contribute to the CRSP on a pre-tax or after-tax Roth basis (or combination of pre-tax and Roth) up to the annual maximum allowed under the Internal Revenue Code. For the 2018 calendar year, the annual deferral maximum is \$18,500 or 100% of your base salary, whichever is less.
 - If you will be age 50 or older this calendar year, you may elect an additional Catch-up contribution amount. For the 2018 calendar year, the maximum Age 50 Catch-up amount is \$6,000.
 - If you have 15 or more years of service with entities associated with The Lutheran Church—Missouri Synod and elected to contribute Service Catch-up amounts prior to 2016, you may be eligible to contribute an additional Service Catch-up amount. For the 2018 calendar year, the maximum Service Catch-up amount is \$3,000.
 - For more information on Catch-up contributions, visit our website at ConcordiaPlans.org/CRSP.
- This Salary Deferral Agreement is a written agreement between you and your employer whereby you direct your employer to reduce your pay by a specific percentage or dollar amount. Your employer then remits the money to your CRSP account. You may change or cancel the amount of your salary deferral contributions at any time as allowed under the terms of the CRSP. Your current Salary Deferral Agreement will continue until you notify your employer otherwise.
- How much should you contribute? The answer depends on your current financial situation, and you may want to speak with a Fidelity Financial Guidance Counselor or other trusted financial professional to take into consideration your entire profile. As a general guideline, it is recommended to have a combined (your contributions plus any employer contributions) retirement savings rate of 15% of pay. But keep in mind, even small amounts add up over time.
- Salary deferral contributions to the CRSP are limited to your taxable income, which does not include housing allowance. Electing to contribute a percentage of your salary (rather than a certain dollar amount per pay period) is an easy way to make sure your savings rate for retirement remains relative to your salary.

