

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

Fax: 314-996-1127
E-Mail: info@ConcordiaPlans.org
Web Site: www.ConcordiaPlans.org

A EMPLOYER INFORMATION PLEASE PRINT OR TYPE ALL INFORMATION

Concordia Plan Services Employer Account Number (if known) _____
Employer Name _____
Address _____
City State Zip Code _____
Employer Phone No. _____ Fax No. _____
Employer E-mail _____ District _____
Worker's Occupation _____ Scheduled No. of Hours per Week _____
Is this worker deployed (works at location other than employer)? Yes No
Full-Time Hire Date* _____ Probationary period expired (if applicable) _____
Mo. Day Year Mo. Day Year

*Full-time for CRP & CDSP purposes is more than 20 hours per week AND more than five consecutive months per year.
Coverage normally begins the first day of the month following the date of full-time employment unless a probationary period applies.

B To enable proper participation in the Concordia Plans for all workers and dependents, please list below any individual(s) of whom the worker and/or spouse may have been a dependent under the Plans as a result of their current/previous LCMS employment. (List could include mother, father, foster-parents, step-parents, legal guardian, previous spouse, etc. if ever employed by LCMS.)

SOCIAL SECURITY NO.	NAME: First, Last	LCMS EMPLOYER
		Name: City/State:

C WORKER INFORMATION

Rev Mrs JUNIOR
 Dr Miss SENIOR
 Mr Ms First Initial Last Previous Last Name

D U.S. SOCIAL SECURITY NUMBER	CANADA SOCIAL INSURANCE NUMBER	E DATE OF BIRTH	F GENDER
		Month Day Year	Male <input type="checkbox"/> Female <input type="checkbox"/>

G Worker's Home Address _____
City State Zip Code _____

H Marital Status
 Single
 Married, Date _____ MO DAY YEAR
 Widowed, Date _____ MO DAY YEAR
 Divorced, Date _____ MO DAY YEAR
(include court documentation)
 Legally Separated, Date _____ MO DAY YEAR
(include court documentation)

I
Home Telephone No. (_____) _____ - _____
Cell Telephone No. (_____) _____ - _____
Fax No. (_____) _____ - _____
E-Mail Address _____
Country in Which You _____
Hold Citizenship _____

J IF YOU ARE MARRIED AND/OR HAVE CHILDREN, SECTIONS J AND K MUST BE COMPLETED.

SPOUSE'S NAME _____
First Initial Last (if different than yours) Previous Last Name
SPOUSE'S DATE OF BIRTH _____
Month Day Year
SPOUSE'S U.S. SOCIAL SECURITY NUMBER _____
SPOUSE'S CANADA SOCIAL INSURANCE # _____
Spouse's LCMS Employer (if applicable) _____
Name City State Zip Code
Date LCMS Spouse's Employment Began _____ Terminated _____ Is Scheduled to Begin _____

K

PLEASE PRINT OR TYPE ALL INFORMATION

Please list your eligible children as described in a, b, and c below. *Even if you don't want to enroll children for health coverage, they may be eligible for death benefit coverage under the Concordia Disability and Survivor Plan (CDSP).*

Note: To be eligible, 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 earnings limits.)

- a) List each unmarried child under age 21.
- b) List each unmarried child age 21 through 26 if a full-time student in an accredited educational institution. **(IMPORTANT: Verification of full-time status must be received before enrollment of this dependent can be approved and processed.)**
- c) List each unmarried child who is age 21 or over AND totally disabled (subject to approval).

A child in active military service is not eligible as a dependent and should not be listed.

Name of Dependent Child First Last (if different)	Sex		Date of Birth	Age	Social Security or Social Insurance #	If Adopted, Foster or Stepchild, Enter Relationship and Date Effective	If Disabled Enter Date Disabled	If Age 21 thru 26, Has Student Status Been Continuous Since Age 21?	
	M	F						Yes	No
						Relationship			
						Date			
						Relationship			
						Date			
						Relationship			
						Date			
						Relationship			
						Date			

IF ADDITIONAL CHILDREN, ATTACH SHEET GIVING INFORMATION REQUESTED ABOVE

L

CONCORDIA HEALTH PLAN (CHP)

All full-time workers, as defined by your employer, are eligible to enroll themselves and any eligible dependents in the CHP if their employer is participating in the plan. **(Ask your treasurer or business manager if you have any questions about the minimum eligibility requirements for health coverage availability.)** If your spouse is eligible to participate in the CHP as a worker either through the same employer as you or a different employer of the LCMS, your spouse is not eligible to be enrolled in the CHP as your dependent. In such case, Class 2 or 4 below should not be checked. Also if your spouse or child is in active military service, neither is eligible to be enrolled in the CHP as your dependent. 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.

YES, Enroll me 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 do not enroll your spouse and/or children at this time, the "Reason for Non-Enrollment" form attached to this enrollment form must be completed. Any future request for CHP enrollment of your dependents 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. Check your Summary Plan Description for more details.

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

If you do not enroll in the CHP at this time, the "Reason for Non-Enrollment" form attached to this enrollment form must be completed. Any future request for CHP enrollment for you and/or your 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. Check your Summary Plan Description for more details. (Pre-existing condition restrictions may apply.)

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 Options Blue HSA Options Blue HRA Option HMO

M

ALL -CAUSE ACCIDENT INSURANCE PROGRAM (AIP)

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 the AIP brochure for details and cost information. Rates can also be found at www.ConcordiaPlans.org.

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

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

N PLEASE PRINT OR TYPE ALL INFORMATION

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 Synodical school from which you graduated

O Check the listing on 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
 - DCE
 - Deaconess
 - Parish Assistant
 - Director of Family Life Ministry
 - Director of Christian Outreach
 - Director of Parish Music
 - Lay Minister
- None of the Above

P Are you currently considered "Self-Employed" by the I.R.S.? Yes No

Do you pay "Self-Employed" Social Security tax? Yes No

Q EARLY ENROLLMENT DATE FOR ASSIGNED WORKER

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: _____

R CONCORDIA RETIREMENT PLAN (CRP) & CONCORDIA DISABILITY & SURVIVOR PLAN (CDSP)

An employer participating in the CRP & CDSP is obligated to enroll all full-time workers regardless of age, sex, occupation, or faith.

CHECK ONLY THE CRP BASIS OF PARTICIPATION APPLICABLE TO THE WORKER.

- REGULAR BASIS.** Available to all workers enrolled in the CRP. A lay worker is only eligible to participate on the Regular Basis.
- FULL BASIS.** Available only to ministers of religion (ordained pastors, commissioned and rostered ministers of religion) and eligible deaconesses who were participating in the CRP as "self-employed" prior to January 1, 1982.

S WORKER SALARY INFORMATION

The salary information you insert 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 the last page. If your congregation is part of a dual parish, report salary information received from each congregation separately as shown in examples on the last page of this form.

Employer Account Number (if known)	LCMS EMPLOYER	1	2		3	4
		BASIC ANNUAL CASH SALARY	ANNUAL AMOUNT FOR HOUSING IF		ANNUAL CASH UTILITY ALLOWANCE PAID TO WORKER	TOTAL SALARY COLUMN 1+2+3
			Home Provided (25% of Column 1)	Cash Paid to Worker		
	NAME: _____					
	CITY/STATE: _____					
	NAME: _____					
	CITY/STATE: _____					
DUAL PARISHES ONLY—ENTER TOTAL SALARY RECEIVED						

T SIGNATURE REPRESENTING EMPLOYER

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 Concordia Plan Services, and to remit such portion along with the portion required by us as the worker's employer.

X _____
SIGNATURE OF ELECTED OR APPOINTED OFFICIAL TITLE DATE

U WORKER'S SIGNATURE

The information entered on this form is current and correct to the best of my knowledge. I understand that any portion of the cost for participation that is my responsibility, according to the provisions of Concordia Plan Services, will be obtained from me and remitted along with the portion required from my employer.

X _____
SIGNATURE OF WORKER DATE

If you are declining or have previously declined coverage under the CHP for yourself or your dependent(s), please check the appropriate reason below to determine if you are an eligible opt-out or an ineligible opt-out as defined by the Minimum Participation Requirements of the CHP. Please note, if you satisfy one of the eligible opt-out reasons as well as an ineligible opt-out reason, please only select the eligible opt-out reason. Example: *If you are covered under your spouse's plan (eligible opt-out) and your employer provides you with pay in lieu of being enrolled in the CHP (ineligible opt-out), you would only select "Covered under spouse's or parent's group health plan."* This form must be completed in order to preserve special enrollment rights under the Concordia Health Plan (CHP) for you and/or your dependents in the future.

A WORKER INFORMATION

Worker's Name (Last, First, Initial)	Suffix (Jr., Sr., etc.)	Worker's Social Security Number	Worker's Phone Number	
Name of LCMS Employer	Street Address	City	State	Zip Code

B OPT-OUT REASON(S)

Check One Reason: *Check appropriate line for yourself, your spouse, or your dependent child(ren) if opting out of 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 under a military plan (TRICARE) as a retiree, a state mandated health plan (e.g., Hawaii), or another country's mandatory health plan while studying 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)
_____	_____	_____	I have other employment, and I am covered under my non-LCMS employer's health plan. (CODE 65)
_____	_____	_____	I am not eligible to be covered under the CHP as I do not satisfy the "minimum hours worked" requirement as established by my LCMS employer. (CODE 55)
_____	_____	_____	Other reason

C OTHER INSURANCE INFORMATION

If CHP coverage is/was declined due to other insurance, you must provide us with all of the information about any other health coverage in effect, and the names and Social Security Numbers of all dependents covered under the other plan. Failure to provide such information may result in the loss of special enrollment rights for the worker and/or their dependents in the future.

Subscriber Name		Subscriber ID#		
Type of Policy (e.g., medical, dental, etc.)		Effective Date		
Name of Insurance Company/Carrier		Policy Number		
Street Address	City	State	Zip Code	Phone Number

List name and Social Security Number of individuals covered under this policy number:

(Continued on reverse side)

D WORKER'S SIGNATURE

I understand that any future request for enrollment in the Concordia Health Plan will be delayed until an open enrollment period is provided, unless I and/or my dependent(s) become eligible for "special enrollment" as outlined below.

X
Signature of Worker _____ Date _____

E TERMS OF SPECIAL ENROLLMENT

Special enrollment: Workers and/or their 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 30 days (unless otherwise indicated – see item "d" below) 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 worker **must** provide a statement at the time coverage is declined indicating the reason for declining coverage, complete policy information about any other health coverage in effect, and the names and Social Security Numbers of all dependents covered under the other plan. Failure to provide such information may result in the loss of special enrollment rights for the worker and/or their dependents in the future. Any break in covered periods must be less than 63 days.
- b. *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.**
- c. *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.**
- d. *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.
- e. *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 **within 30 days** after the marriage, birth, adoption, or placement for adoption.
- f. *Certification.* A certificate 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.*

All questions about special enrollment should be directed to Concordia Plan Services. Call toll-free 888-927-7526 or send an e-mail to info@ConcordiaPlans.org.

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

EMPLOYER'S INSTRUCTIONS FOR ENTERING SALARY INFORMATION

COLUMN 1—BASIC ANNUAL CASH SALARY. Round figures in all columns to nearest dollar. Enter the basic annual cash salary. **DO NOT** include any residence allowance, cash housing allowance, cash utility allowance, or car and travel allowance. **DO NOT** include salary adjustments that may be given later in the year. In the event this worker will be leaving your employ during the calendar year, such as the end of the school year or sooner, enter the basic annual cash salary the worker would receive if he or she remained in your employ for a calendar year. In the event this worker is entering your employ after the first of the calendar year, such as the beginning of the school year or later, enter the basic annual cash salary the worker would have received if he or she had begun their employment at the first of the calendar year. When workers are paid on an hourly basis, their annual salary to be reported can be determined by multiplying their hourly wage by the number of hours it is estimated they will or would have worked during the current year. **A FIGURE MUST BE ENTERED IN COLUMN 1.**

COLUMN 2—ANNUAL AMOUNT FOR HOUSING. If a home (primary residence) is provided for this worker by the employer, enter 25% of the amount in Column 1 under HOME PROVIDED. If a CASH allowance is paid directly to the worker by the employer for housing, enter the annual amount under CASH PAID TO WORKER. It is possible that a worker is provided a home and also paid a cash housing allowance directly. In such case a figure should be inserted in Column 2 under both HOME PROVIDED and CASH PAID TO WORKER. If no housing or cash allowance is provided the worker, leave this column blank.

HUSBAND AND WIFE BOTH ENROLLED IN THE CONCORDIA PLANS. When a husband and wife are both enrolled and residing in a home provided by an employer, an amount should be entered in Column 2 under HOME PROVIDED for the individual(s) whose salary agreement with the employer includes the housing provisions.

COLUMN 3—ANNUAL CASH UTILITY ALLOWANCE. Enter the annual amount of cash utility allowance, if any, paid directly to the worker. **DO NOT** include utility payments made to a utility company by the employer. If a cash utility allowance is not paid to the worker, leave this column blank. **DO NOT** use this or any column to report a car allowance as a car allowance is not used in computing annual salary for purposes of the Concordia Plans.

COLUMN 4—TOTAL SALARY THIS YEAR. The figure to be entered in this column is found by adding any figures entered in column 2 and 3 to the figure in Column 1. **A FIGURE MUST BE ENTERED IN COLUMN 4.**

EXAMPLES FOR DUAL PARISH REPORTING

EXAMPLE 1—Only one congregation provides the home.

Employer Account Number (if known)	LCMS EMPLOYER	1	2		3	4
		BASIC ANNUAL CASH SALARY	Home Provided (25% of Column 1)	Cash Paid to Worker	ANNUAL CASH UTILITY ALLOWANCE PAID TO WORKER	TOTAL SALARY COLUMN 1+2+3
ER99999	NAME: St. John Lutheran Church CITY/STATE: Anywhere, MN	20,000	5,000			25,000
ER88888	NAME: Trinity Lutheran Church CITY/STATE: Somewhere, MN	12,000				12,000
DUAL PARISHES ONLY—ENTER TOTAL SALARY RECEIVED		32,000	5,000			37,000

EXAMPLE 2—Both congregations provide a cash housing allowance.

Employer Account Number (if known)	LCMS EMPLOYER	1	2		3	4
		BASIC ANNUAL CASH SALARY	Home Provided (25% of Column 1)	Cash Paid to Worker	ANNUAL CASH UTILITY ALLOWANCE PAID TO WORKER	TOTAL SALARY COLUMN 1+2+3
ER77777	NAME: Our Redeemer Lutheran Church CITY/STATE: Hometown, NE	20,000		3,000	1,000	24,000
ER66666	NAME: Grace Lutheran Church CITY/STATE: Ourtown, NE	20,000		3,000	1,000	24,000
DUAL PARISHES ONLY—ENTER TOTAL SALARY RECEIVED		40,000		6,000	2,000	48,000