



**Concordia Disability and Survivor Plan (CDSP) – Life Insurance Benefits**

Please list your eligible children as described in a, b, and c below. **Failure to enroll eligible children will result in decreased death benefits.** 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).

- a) List each unmarried child under age 21 and not on active military duty.
- b) List each unmarried child age 21 up to age 27 if a full-time student in an accredited educational institution and attach to this form proof of full-time student status.
- c) List each unmarried child who is age 21 or over AND totally disabled prior to attaining age 21 or became totally disabled while a full-time student in an accredited educational institution (subject to approval).

**Concordia Health Plan (CHP) – Medical and Dental Benefits**

To enroll your children, review d, e, and f below for eligibility of children as dependents for the CHP. You may be required to submit a birth certificate or legal paperwork.

- d) A child (biological, legally adopted, step, or foster child) up to age 26 regardless of student or marital status (unless the child is eligible for employer-sponsored coverage where the child or the child’s spouse works).
- e) An unmarried totally disabled child (biological, legally adopted, step, or foster child) who became disabled before attaining age 26 (subject to approval).
- f) An unmarried grandchild or step-grandchild who lives with the member, whose gross income for the year is less than the federal exemption amount defined by the IRS, and is receiving over 50% of financial support from the member. Contact Concordia Plan Services regarding age limits and other requirements.

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

| Name of Dependent      |       | CDSP<br>a, b,<br>or c | CHP<br>d, e,<br>or f | Sex |   | Date<br>of<br>Birth | Social Security<br>Number<br><b>(Required for<br/>Enrollment)</b> | If Adopted or<br>Foster Child<br>include legal<br>documentation | If Disabled<br>Enter Date<br>Disabled |
|------------------------|-------|-----------------------|----------------------|-----|---|---------------------|---|---|---------------------------------------|
| Last<br>(if different) | First |                       |                      | M   | F |                     |   |   |                                       |
|                        |       |                       |                      |     |   | __/__/__            |   | Status<br>Date __/__/__   | __/__/__                              |
|                        |       |                       |                      |     |   | __/__/__            |   | Status<br>Date __/__/__   | __/__/__                              |
|                        |       |                       |                      |     |   | __/__/__            |   | Status<br>Date __/__/__   | __/__/__                              |
|                        |       |                       |                      |     |   | __/__/__            |   | Status<br>Date __/__/__   | __/__/__                              |

IF ADDITIONAL CHILDREN, ATTACH SHEET GIVING INFORMATION AS REQUESTED ABOVE.

**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 employer representative 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. An eligible child of a married couple who are both LCMS workers can be covered as an eligible family member by only one worker. 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 eligible 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 eligible 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 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. Check your Summary Plan Description for more details. (Pre-existing condition restrictions may apply.)

*If 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-C2

**L****REASON FOR NON-ENROLLMENT IN THE CONCORDIA HEALTH PLAN****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 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)  |
| _____  | _____            | _____                | 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 (CODE 70): _____   |

**M****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 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. Failure to enroll within the 30-day period may result in delayed enrollment until the next Open Enrollment period.
- 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.*

**N****WORKER'S SIGNATURE**

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 above.

**X**

SIGNATURE OF WORKER

DATE

**O 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](http://www.ConcordiaPlans.org).

AIP eligibility requirements for children follow the same guidelines as the CDSP.

- 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 |

**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 Synodical school from which you graduated

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

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

**S 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: \_\_\_\_\_

**Q** 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                       Director of Family Life Ministry
  - DCE                               Director of Christian Outreach
  - Deaconess                       Director of Parish Music
  - Parish Assistant               Lay Minister
- None of the Above

**T CONCORDIA RETIREMENT PLAN (CRP) PARTICIPATION BASIS**

Ordained and commissioned ministers of religion (1) who were participating in the CRP prior to January 1, 1982; (2) who were deemed to be a self-employed person under Social Security laws and who self-employed status did not subsequently terminate; and (3) whose participation in the CRP as a worker has not subsequently terminated for a period more than 5 years may be eligible to participate in the CRP on a FULL BASIS.

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

**U 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 pages 5-6. 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                         |
|--|---------------|--|---------------------------------|---------------------|--|---------------------------|
|  |               | ANNUAL CASH SALARY PAID OVER 12-MONTH PERIOD | 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 |               |  |                                 |                     |  |                           |

**V 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 the Concordia Plans, 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

**W 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 the Concordia Plans, will be obtained from me and remitted along with the portion required from my employer.

**X** \_\_\_\_\_  
 SIGNATURE OF WORKER DATE

**X EMPLOYER'S INSTRUCTIONS FOR ENTERING SALARY INFORMATION**

**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 tax-sheltered annuity (TSA)
  - 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)
- 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 the coming year. (A suggested guide would be to judge from the hours actually worked the previous year.)
- If you have a worker receiving a salary from two or more congregations, only one form is required and is sent to you as the "contact congregation" for completion. (List the salary 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 pay over a compressed work year, (e.g. teachers), please report the salary they earn for the entire year, regardless of how it is paid out.

**COLUMN C – PROVIDED HOUSING.** 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 salary 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 SALARY.** 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 DUAL PARISH SALARY REPORTING**

**EXAMPLE 1 – BOTH CONGREGATIONS PROVIDE A CASH HOUSING ALLOWANCE**

|                  | A  | B                              | C                                 | D                                      | E                                      | F   |                            |
|------------------|--|--------------------------------|-----------------------------------|--|--|---|----------------------------|
| WORKER'S NAME    | TOTAL SALARY<br>Includes amount for<br>home provided | HOURS<br>WORKED<br>PER<br>WEEK | BASIC<br>ANNUAL<br>CASH<br>SALARY | HOME<br>PROVIDED<br>25% OF<br>COLUMN B | ANNUAL<br>CASH<br>HOUSING<br>ALLOWANCE | ANNUAL<br>CASH<br>UTILITY<br>ALLOWANCE<br>PAID TO<br>WORKER | TOTAL<br>SALARY<br>B+C+D+E |
| JONES, ROBERT C. | 40,000   |                                |                                   |  |  |   |                            |
| <b>St. John</b>  | >40  | 20                             | 17,000                            |  | 4,500                                  | 1,200   | 22,700                     |
| <b>Trinity</b>   |  | 20                             | 15,000                            |  | 3,500                                  | 1,200   | 19,700                     |
|                  |  |                                | 32,000                            |  | 8,000                                  | 2,400   | 42,400                     |

**EXAMPLES FOR DUAL PARISH SALARY REPORTING—continued**

**EXAMPLE 2 – ONE CONGREGATION PAYS ALL THE COSTS OF A HOME PROVIDED**

|                      | <b>A</b>  | <b>B</b>                     | <b>C</b>                        | <b>D</b>                             | <b>E</b>                             | <b>F</b>  |                             |
|----------------------|---|------------------------------|---------------------------------|--------------------------------------|--------------------------------------|---|-----------------------------|
| <b>WORKER'S NAME</b> | <b>TOTAL SALARY</b><br>*Includes amount for home provided | <b>HOURS WORKED PER WEEK</b> | <b>BASIC ANNUAL CASH SALARY</b> | <b>HOME PROVIDED 25% OF COLUMN B</b> | <b>ANNUAL CASH HOUSING ALLOWANCE</b> | <b>ANNUAL CASH UTILITY ALLOWANCE PAID TO WORKER</b> | <b>TOTAL SALARY B+C+D+E</b> |
| SMITH, DAVID A.      | <b>39,000*</b>  |                              |                                 |                                      |                                      |   |                             |
| <b>Grace</b>         | <b>&gt;40</b>   | <b>35</b>                    | <b>25,000</b>                   | <b>6,250</b>                         | <b>900</b>                           | <b>900</b>  | <b>33,050</b>               |
| <b>Immanuel</b>      |   | <b>15</b>                    | <b>10,000</b>                   | <b>0</b>                             | <b>0</b>                             | <b>0</b>  | <b>10,000</b>               |
|                      |   |                              | <b>35,000</b>                   | <b>6,250</b>                         | <b>900</b>                           | <b>900</b>  | <b>43,050</b>               |

**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.**

|                      | <b>A</b>   | <b>B</b>                     | <b>C</b>                        | <b>D</b>                             | <b>E</b>                             | <b>F</b>  |                             |
|----------------------|--|------------------------------|---------------------------------|--------------------------------------|--------------------------------------|---|-----------------------------|
| <b>WORKER'S NAME</b> | <b>TOTAL SALARY</b><br>Includes amount for home provided | <b>HOURS WORKED PER WEEK</b> | <b>BASIC ANNUAL CASH SALARY</b> | <b>HOME PROVIDED 25% OF COLUMN B</b> | <b>ANNUAL CASH HOUSING ALLOWANCE</b> | <b>ANNUAL CASH UTILITY ALLOWANCE PAID TO WORKER</b> | <b>TOTAL SALARY B+C+D+E</b> |
| MEYER, JAMES P.      | <b>39,000</b>  |                              |                                 |                                      |                                      |   |                             |
| <b>Christ</b>        | <b>&gt;40</b>  | <b>20</b>                    | <b>17,000</b>                   | <b>4,250</b>                         |                                      | <b>900</b>  | <b>22,150</b>               |
| <b>Good Shepherd</b> |  | <b>20</b>                    | <b>15,000</b>                   | <b>3,750</b>                         |                                      | <b>900</b>  | <b>19,650</b>               |
|                      |  |                              | <b>32,000</b>                   | <b>8,000</b>                         |                                      | <b>1,800</b>  | <b>41,800</b>               |

**EXAMPLE 4 – ONE PARISH OWNS HOME BUT SECOND PARISH PAYS A CASH HOUSING ALLOWANCE DIRECTLY TO WORKER**

|                      | <b>A</b>   | <b>B</b>                     | <b>C</b>                        | <b>D</b>                             | <b>E</b>                             | <b>F</b>  |                             |
|----------------------|--|------------------------------|---------------------------------|--------------------------------------|--------------------------------------|---|-----------------------------|
| <b>WORKER'S NAME</b> | <b>TOTAL SALARY</b><br>Includes amount for home provided | <b>HOURS WORKED PER WEEK</b> | <b>BASIC ANNUAL CASH SALARY</b> | <b>HOME PROVIDED 25% OF COLUMN B</b> | <b>ANNUAL CASH HOUSING ALLOWANCE</b> | <b>ANNUAL CASH UTILITY ALLOWANCE PAID TO WORKER</b> | <b>TOTAL SALARY B+C+D+E</b> |
| SCHMIDT, THOMAS C.   | <b>40,000</b>  |                              |                                 |                                      |                                      |   |                             |
| <b>Holy Cross</b>    | <b>&gt;40</b>  | <b>20</b>                    | <b>17,000</b>                   | <b>4,250</b>                         | <b>0</b>                             | <b>1,000</b>  | <b>22,250</b>               |
| <b>Zion</b>          |  | <b>20</b>                    | <b>16,000</b>                   | <b>0</b>                             | <b>900</b>                           | <b>1,000</b>  | <b>17,900</b>               |
|                      |  |                              | <b>33,000</b>                   | <b>4,250</b>                         | <b>900</b>                           | <b>2,000</b>  | <b>40,150</b>               |

**Note:** This 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.