

**CONCORDIA HEALTH PLAN
SPECIAL ENROLLMENT APPLICATION**

The Lutheran Church—Missouri Synod
Concordia Plan Services
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WORKER INFORMATION

Name: Title First Initial Last Suffix (Jr., Sr., etc.) Previous Last Name

Social Security Number Date of Birth (Month/Day/Year)

Home Address

City State Zip Code

Marital Status MONTH DAY YEAR Home Phone Number Cell Phone Number

Single

Married, Date _____

Widowed, Date _____

Divorced*, Date _____

Legally Separated*, Date _____

** include court documentation*

Fax Number

E-mail Address

Country in which you hold citizenship

CONCORDIA HEALTH PLAN ELECTION

Please check your desired level of coverage from the following:

- Self Only (Class 1)
- Self and Spouse (Class 2)
- Self and Child(ren) (Class 3)
- Self, Spouse, and Child(ren) (Class 4)

If your employer offers Worker Choice, please check your desired plan coverage option from the options offered by your employer (individual deductible amount in parenthesis):

- Option A (\$0)
- Option B (\$300)
- Option C (\$500)
- Option D (\$1,000)
- Options Blue HRA (\$1,200)
- Options Blue HSA (\$2,500)
- Option HMO (no deductible) *only in limited areas*
- Option HMO-C2 (no deductible) *only in limited areas*

IMPORTANT NOTICE REGARDING SPECIAL ENROLLMENT IN THE CONCORDIA HEALTH PLAN

If you previously declined enrollment in the Concordia Health Plan (CHP) for you, your spouse, and/or dependent children, please state below the reason you declined CHP coverage:

Please complete all of the following information and return this form with a HIPAA Certificate of Prior Coverage for the terminated coverage to our office. NOTE: If you are unable to promptly obtain a HIPAA Certificate, please submit this application and send a copy of the HIPAA Certificate once you have received it. The information submitted will be reviewed to determine special enrollment eligibility in the CHP. If all the requirements are met, eligibility for coverage will be the first of the month following the receipt of your initial written request, or, for transferring workers, following your date of full-time employment at your new employer.

Are you requesting coverage for yourself and/or your dependents because you and/or dependent(s) were covered under another health plan and are now no longer eligible for such coverage? YES NO

Please provide information regarding the other insurance:

Type of Policy (e.g., medical, dental, etc.)

Name of Insurance Company/Carrier Policy Number

Street Address City, State, Zip Code Phone Number

Date other coverage began: _____ Date other coverage terminated: _____

Reason other coverage terminated: _____

We **must** have a copy of the HIPAA Certificate of Prior Coverage for each individual for whom coverage is being requested. A COBRA extension form CANNOT be accepted as a HIPAA Certificate of Prior Coverage. List name and Social Security number of individuals covered under the other policy number:

Name of Dependent(s)

Date of Birth

Social Security Number

Member AND Employer Representative must sign below:

Member's Signature _____ Date _____

Signature of Authorized
Employer Representative _____ Date _____

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. Workers at Worker Choice employers (those who offer more than one CHP Option) may also change their CHP Option if they qualify for special enrollment. 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. To be eligible for special enrollment, the worker must have declined coverage due to coverage under another plan. 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. Effective April 1, 2009.* Group health plans and health insurance carriers are required to permit a worker (or dependent of the worker) who is eligible—but not enrolled for coverage—to 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.*

(The fraud and abuse provisions in HIPAA [Health Insurance Portability and Accountability Act] make it a crime to submit a false statement to an employee benefit plan.) All questions about special enrollment should be directed to Concordia Plan Services at 888-927-7526 or send an e-mail to info@ConcordiaPlans.org.