

SECTION E**CHILDREN INFORMATION**

If you wish to enroll a child not currently enrolled, review a, b, and c below for eligibility of children as dependents.

- a) An unmarried child under age 21. For a foster child to be eligible you must provide 51% or more financial support.
- b) An unmarried child age 21 through 26, if a full-time student in an educational institution, and if you provide 51% or more financial support for such student.
- c) An unmarried totally disabled child, age 21 or over, if so disabled before attaining age 21.

Name of Dependent		Sex		Date of Birth	Age	Social Security Number	If Adopted, Foster or Stepchild. Enter Status and Date Effective	If Disabled Enter Date Disabled	If in College Enter Date of Full-Time Student Status	Health Plan Coverage Desired?	
Last (if different)	First	M	F							Yes	No
							Status				
							Date				
							Status				
							Date				

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

SECTION F**REQUEST TO TERMINATE MEMBER HEALTH COVERAGE**

Please terminate my participation in the Concordia Health Plan. Reason: _____
Coverage will end effective with the end of the month in which this form is received in the Worker Benefit Plans office.

I understand that future enrollment will be subject to the Plan provisions in effect at that time, which may include having to satisfy special enrollment requirements or waiting for an open enrollment period.

SECTION G**REQUEST TO TERMINATE DEPENDENT COVERAGE**

Coverage normally ends at the end of the month in which the dependent ceases to be an eligible dependent or this form is received in the Worker Benefit Plans office. Late notice may require payment of contributions beyond the normal termination date.

I understand that future enrollment will be subject to the Plan provisions in effect at that time, which may include having to satisfy special enrollment requirements or waiting for an open enrollment period.

NAME	RELATIONSHIP	REASON FOR DELETION	DATE EVENT OCCURRED

SECTION H**REQUEST TO CHANGE RETIREMENT PLAN PARTICIPATION**

Full Basis is available only for ministers of religion or deaconesses who were Concordia Retirement Plan members on December 31, 1981, and who have continuously been members and self-employed under Social Security since that date.

Please change participation to _____ basis effective _____.
Enter either (full) or (regular) Enter first day of any calendar month

SECTION I**WORKER AND EMPLOYER SIGNATURES**

The information entered on this form by me is current and correct to the best of my knowledge. I authorize my employer to obtain any portion of the cost required by me, according to the Plan provisions, for my participation in any of the Worker Benefit Plans, and to remit such portion along with the portion required of my employer.

X _____
SIGNATURE OF WORKER DATE

The employment 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 required from the worker, according to the Plan provisions, for the worker's participation in any of the Worker Benefit Plans, and to remit such portion along with the portion required by us as an employer.

X _____
SIGNATURE OF EMPLOYER REPRESENTATIVE DATE