

Dependent's Full Name	Relationship	Date of Birth	Social Security Number	Add	Remove	Reason
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

If you are removing dependents from your CHP coverage, please enter 1, 2, or 3 to indicate the reason: 1) No longer eligible, 2) Has other group coverage, 3) other.

E Open Enrollment Agreement

NOTE: If you are enrolling yourself or any eligible dependents through Annual Open Enrollment and are choosing Option A, B, C, or D, or Options Blue HSA or HRA, the following information about providing a HIPAA certificate and the pre-existing condition limitation applies to you. Call 888-927-7526 if you have any questions. Please initial each statement below.

- I understand that a pre-existing condition limitation is a part of Annual Open Enrollment, and that if I, or any of my eligible dependents, should have a medical condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately prior to the Concordia Health Plan (CHP) enrollment date of January 1, 2010, then no CHP coverage (with the exception of prescription drugs, the Employee Assistance Program, dental, or care received for pregnancy or for a child who is enrolled in CHP within 30 days after birth, adoption, or placement for adoption) will be provided for that condition during the first 18 months of CHP membership. This limitation applies to me or any of my dependents with a pre-existing condition who are being enrolled through Annual Open Enrollment. **Initial here:** _____
- However, if I provide a HIPAA certificate of prior creditable coverage or other means described in the following paragraph, I understand that the 18-month limitation period can be reduced by the number of months I or my dependent(s) had prior medical coverage under another group health plan, HMO, individual health insurance, Medicaid, or Medicare and as long as the gap in coverage between the other health coverage and the effective enrollment date of the CHP is less than 63 days. **Initial here:** _____
- I understand that if I, or any of my eligible dependents, have prior health coverage that we must provide Concordia Plan Services with a HIPAA certificate of prior creditable coverage or other evidence of prior health coverage explained in the CHP plan document. Concordia Plan Services can provide assistance to you in obtaining the HIPAA certificate of prior creditable coverage, if you experience a problem with the prior carrier. **Initial here:** _____
- If no HIPAA certificate is provided to Concordia Plan Services, I understand that the full 18-month pre-existing limitation period following enrollment will be in effect. **Initial here:** _____

F Worker Signature and Payroll Authorization

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 (if applicable), according to the Plan provisions, for my participation in any of the Concordia Plans, and to remit such portion along with the portion required of my employer. I also understand that any and all changes listed on this form will be effective January 1, 2010. If terminating CHP coverage, 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.)

 Worker's Signature Date

G Employer Authorization

As the employer representative, I acknowledge that the information entered on this form for this worker is complete and accurate to the best of my knowledge.

Mary Arnold 651-641-8268 marnold@csp.edu
 Print Name Phone E-Mail

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 Signature/Position of Authorized Employer Representative Employer Number Date

Workers should return this form to their HR or Business Manager by their requested deadline.
 Employers must have enrollment information to Concordia Plan Services by November 20, 2009

Please make sure that all requested information is provided on this form;
 missing information will delay the processing of the application or may result in the application being denied.