



Lutheran Benefits Health Enrollment Form Benefits Enrollment Form



1-800-516-HAHN

lutheranbenefits@hahnfinancialgroup.com

Registered Representative of and securities offered through OneAmerica Securities, Inc., Member FINRA, SIPC, a Registered Investment Advisor, Hahn Financial Group, Inc, 3101 S. Phillips Avenue, Sioux Falls, SD 57105; (605) 275-3600. Insurance Representative of American United Life Insurance Company® (AUL) and other insurance companies. Hahn Financial Group, Inc. is not an affiliate of OneAmerica Securities or AUL and is not a broker dealer or Registered Investment Advisor.

In this package you will find six key pieces of information.

- A "Health Benefits Highlights" Sheet
- A Health "Enrollment Form" Instruction Sheet
- A Health "Enrollment Form"
- A "Benefits Enrollment Form" Instruction Sheet
- A "Benefits Enrollment Form"
- A church "ACH Process Form"
- And "Document Checklist and Submission Instructions"

To successfully complete these forms you will need to gather some key pieces of information concerning yourself, your dependents and your beneficiaries. That information includes:

- Names
- Addresses
- Dates of Birth (mm/dd/yyyy)
- Social Security Numbers
- Your Annual Salary
- If you are electing coverage for a spouse you must provide a copy of your marriage certificate. PLEASE NOTE: This plan does not cover same sex marriages or domestic unions.
- If you are electing coverage for dependents you must provide a photocopy of their state or county issued birth certificate. PLEASE NOTE: This plan does not cover abortions.

If you need assistance completing these forms please call Hahn Financial Group, Inc. at 1-800-516-HAHN (4246) or send an email to lutheranbenefits@hahnfinancialgroup.com.



NALC
North American Lutheran Church

LUTHERAN
CORE

HEALTH BENEFIT HIGHLIGHTS

"A comprehensive health benefit package is an important part of our daily lives. It is our pleasure to present these highlights from our benefits package.* Our hope is that you will join us on our informational webinars and carefully consider the benefits of joining the plan with us."

-Bishop John Bradosky, Bishop, NALC

-Pastor Mark Chavez, General Secretary, NALC

1. Health plan* with an annual deductible of \$400/singles and \$1,200/families. Max out of pocket expenses per individual of \$2,000. In addition, there is a prescription drug plan (plan does not cover abortions, same sex marriage or domestic unions).
2. Dental insurance that goes beyond cleaning, cavities and root canal coverage and includes dentures and orthodontia.
3. A \$50,000.00 base life insurance policy with the option to purchase an additional \$100,000.00 without underwriting (spouse and dependent children can be covered on a voluntary basis).
4. Short and Long Term Disability - protecting a portion of your income to age 65.
5. An Employee Assistance Program that provides counseling and other services (a large portion of unscheduled doctor's visits are stress related).
6. A base \$10,000.00 Critical Illness Policy that will pay you cash in the event of cancer, heart attack or stroke. You have the option to purchase \$10,000.00 of additional benefit without underwriting.
7. An Optional Flexible Spending Account that not only has options to save for medical and day-care expenses but also for parking and transportation expenses.
8. An optional Vision Plan covering exams, lenses and contacts.

*Medical and Rx benefits are provided by the Central States Joint Board Health and Welfare Fund to Members of Chemical and Productions Workers Union Local 30.

LUTHERAN BENEFITS HEALTH PACKAGE	PKG A	PKG B	PKG C	PKG D
	EMPLOYEE ONLY	EMPLOYEE + CHILD	EMPLOYEE + SPOUSE	EMPLOYEE + FAMILY
HEALTH	√	√	√	√
DENTAL (requires opt out)	√	√	√	√
LIFE (BASE LIFE)	√	√	√	√
SHORT TERM DISABILITY	√	√	√	√
LONG TERM DISABILITY	√	√	√	√
EAP + WELLNESS	√	√	√	√
CRITICAL ILLNESS	√	√	√	√
VISION (optional)	√	√	√	√



PACKAGE "C" FOR A 55-YEAR-OLD PASTOR(non-tobacco) EARNING \$54,000 ANNUALLY WOULD COST APPROXIMATELY \$1,100 PER MONTH IN 2011

PACKAGE "D" FOR A 35-YEAR-OLD PASTOR(non-tobacco) EARNING \$36,000 ANNUALLY WOULD COST APPROXIMATELY \$1,300 PER MONTH IN 2011



BENEFITS SERVICED BY
HAHN FINANCIAL GROUP, INC.
1-800-516-HAHN (4246)

Registered Representative of and securities offered through OneAmerica Securities, Inc., Member FINRA, SIPC, a Registered Investment Advisor, Hahn Financial Group, Inc, 3101 S. Phillips Avenue, Sioux Falls, SD 57105; (605) 275-3600. Insurance Representative of American United Life Insurance Company® (AUL) and other insurance companies. Hahn Financial Group, Inc. is not an affiliate of OneAmerica Securities or AUL and is not a broker dealer or Registered Investment Advisor.

Lutheran Benefits Health “Enrollment Form” Instructions

This form will be used to enroll you into the Health Insurance portion of the Lutheran Benefits health package.

Section I. Employee Information

We need to know a little bit about you: who you are, where you live, how to contact you, your date of birth, marital status and social security number. Please print all of the information.

Section II. Coverage level Election

You may select from one of four tiers of coverage: employee only, employee+spouse, employee+children, employee+family. As with any change in coverage, if you add or terminate coverage for a dependent, certain documentation must be provided.

Your dependent children are eligible for coverage until age 26, even if they do not live with you or depend upon you for their support. However, a dependent child who is employed is not eligible for benefits if he/she is eligible for employer-sponsored health insurance coverage through his/her employer or through his/her spouse's employer.

Section III. Dependent Information

Please provide all information for eligible dependents to be covered under the plan. Please be sure to check the box asking if your dependents are employed. And if necessary, please attach an additional sheet to list your spouse and dependents.

Section IV. Employee Authorization

Please read this statement carefully. When you have read it, please print your name, sign and date.

Section V. Adult Dependent Child Authorization (Ages 19-26)

You and your adult dependent will read this and your dependent must sign and date at the bottom of the page. Please print additional pages if you have more than one “Adult Dependent Child”.

Paperwork must be received IN GOOD ORDER by the 12th of each month to be included in the next month's effective date. Generally, the coverage you elect will be effective the 1st of the month following your enrollment month and will remain effective for one year (provided you remain eligible for coverage). However, under certain circumstances, you may change your coverage election. You are allowed to change coverage for qualifying events such as death, divorce and marriage.

You may also add coverage for your eligible dependent(s) if you did not enroll him/her because they had other coverage and the coverage ends (including a loss of coverage due to reaching a plan maximum).

Or you may terminate coverage for your eligible dependent(s) if your dependent loses eligibility for plan coverage due to reaching age 26, covered under another health plan (including Medicare) or other qualifying events.

You must request a change in coverage within 60 days of the date of the event that qualifies for this special enrollment including COBRA coverage. Therefore, it is very important that you make notification of any changes as soon as possible to request a special enrollment.

You are done with this form.

If you need assistance completing these forms please call Hahn Financial Group, Inc. at 1-800-516-HAHN (4246) or send an email to lutheranbenefits@hahnfinancialgroup.com.

Enrollment Form

Please complete, sign, and return this form to the Fund Office* Please print all information,

Employee Information

Employee Full Name: _____ Employee SS#: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Date of Birth: _____ Shop (Church): _____
Marital Status: Single Married Divorced Widowed

Coverage Level Election

I elect the following coverage level under the Central States Joint Board Health & Welfare Trust Fund:

- Employee Only, with a monthly contribution rate of \$ 0
- Employee Plus Children, with a monthly contribution rate of \$ 0
- Employee Plus Spouse, with a monthly contribution rate of \$. 0
- Employee Plus Family (Spouse and Child(ren) , with a monthly contribution rate of \$ 0

Dependent Information

Provide all information for eligible dependents to be covered under the Plan (attach additional page, if necessary).

Full Name (First, I, Last)	Relationship	Sex		Social Security Number	Date of birth	Check if Employed
		F	M			
		<input type="checkbox"/>	<input type="checkbox"/>		__/__/__	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		__/__/__	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		__/__/__	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>		__/__/__	<input type="checkbox"/>

Employee Authorization

Employee Authorization

I understand that if I elect not to cover a dependent at this time, I will not be able to enroll my dependent until the next enrollment period, unless a special enrollment is necessary. By selecting a coverage level, signing, and submitting this form, I understand this election will remain in effect until the end of the calendar year for which this form is signed and I authorize the applicable contribution rate for this coverage, if any, be deducted from my paycheck. I understand that by electing coverage for a dependent child, I am certifying that the dependent child is not eligible for insurance coverage through his/her employer or through his/her spouse's employer. Moreover, I certify that I will promptly advise the Central States Joint Board Health & Welfare Fund if my dependent child's employer or his/her spouse's employer offers health coverage even if my dependent child elects not to receive coverage through his/her employer or his/her spouse's employer. I hereby certify that the information on this form, to the best of my knowledge and belief, is true, correct, and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment.

Employee's Name (print): _____

Employee's Signature: _____ Date: _____

Completion of this enrollment form is not a guarantee of eligibility or benefits.

_____ Initials of Company Representative for approval of enrollment form due to change, addition or open enrollment.

Adult Dependent Child Authorization (Ages 19-26)

I understand that my parent is seeking to enroll me for benefits under the Central States Joint Board Health & Welfare Fund. By signing below, I hereby certify that I am not eligible to enroll in any employer-sponsored health plan. I understand that this means that neither my employer nor my spouse's employer offers coverage to me regardless of the costs. Moreover, I certify that I will promptly advise the Central States Joint Board Health & Welfare Fund if my Employer or my spouse's employer offers health coverage even if I elect not to receive coverage through my employer or my spouse's employer. I hereby certify that the information on this form, to the best of my knowledge and belief, is true, correct, and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment.

Employee's Name: _____

Employee's SS# _____

Dependant's Name (print): _____

Employer's Name: _____

Employer's Insurance Company: _____

Spouse's Name: _____

Spouse's Employer's Name: _____

Spouse's Employer's Insurance Company: _____

Dependent Child's Signature: _____ Date: _____

Completion of this enrollment form is not a guarantee of eligibility or benefits.

Lutheran Benefits
“Benefits Enrollment Form” Instructions
(Form # LBEF 11-11)

This form will be used to enroll you into the Life, Disability, Critical Illness and Employee Assistance Program that come as part of your Lutheran Benefits Health Package. This form will also be used to voluntarily enroll into the Dental, Vision and Flexible Spending Account portion of Lutheran Benefits. Please print except where a signature is required.

Section I. Employee Information Section

We need to know a little bit about you: who you are, where you live, how to contact you, your date of birth and social security number. If you are also electing coverage for your spouse and/or children, we need to know their names, date of birth and social security numbers. Because some insurances require more information, we also need to know if you are male or female, married or single, if you use tobacco and if you're currently covered under Medicare.

Section II. Church Information Section

In this section we need to know where you work. This is an employer based plan for The North American Lutheran Church and The Lutheran CORE members so we need to know which church you are employed by and how to contact that church. Also, please provide us with your church denomination such as: NALC, ELCA or LCMC.

Section III. Beneficiary Information Section

Employees electing health coverage will be covered with a base \$50,000.00 life insurance policy. Please fill out who will be the beneficiary, if an event occurs. We will need their name, date of birth and social security number, if not listed in Section I. There is also a place to designate if the beneficiary is the primary or a contingent beneficiary; this means, if the primary beneficiary is not able to receive the death benefit the contingent beneficiary will receive the benefit.

Section IV. Benefits Elections Selection

Medical Coverage: You may select from one of four tiers of coverage: employee only, employee/spouse, employee/child(ren) or family. If you do not want any coverage please leave blank. If you are covered under Medicare but would like to elect coverage for your spouse or dependents please check the box stating so.

Dental and Vision Coverage: When electing dental and/or vision coverage the coverage tier must be the same as the medical you selected. If you do not want dental or vision please leave the box blank. **Please note: If you do not elect dental coverage at this time you will not be eligible to enroll for three years from the date of this application. Additionally, to receive complete dental benefits proof of prior coverage is necessary.**

Flexible Spending Account Selection: The flexible spending account allows you to have pretax dollars set aside for medical expenses, dependent care expenses or transportation and parking expenses if you take public transit. If you elect this coverage please let us know the amount you want to set aside and what your payroll interval is.

Additional Options: By participating in Lutheran Benefits you have access to additional Life Insurance coverage, Critical Illness Insurance and voluntary Accident Expense Insurance. If you would like to be contacted concerning these benefits please check the appropriate box.

Section V. Special Benefit Elections Section

Typically, an employee will enroll into the plan, elect one of the four tiers of medical coverage and receive the base Life Insurance, Disability Insurance and Critical Illness Insurance. This special election is active when a married couple both work for the same denomination/organization and the spouse also wants the base Life, Disability and Critical Illness Insurance. Additionally, the spouse is also able to elect additional voluntary Life, Critical Illness and their own Accident Expense policy.

Section VI. Change of Coverage (Qualifying Events) Section

This is the section that gives the reasons why a person would be allowed to enroll into the plan outside of the 90 day open enrollment period. Please provide us the reason for the exception and the date that the event occurred. Please leave blank if enrolling during the 90 day open enrollment period.

Section VII. Declination of Coverage Section

If you left the Medical, Dental, Vision or Flexible Spending Account election boxes blank in Section IV this is the section to confirm that you elect to decline coverage. When declining coverage, please state why you are declining the coverage (for example: have coverage under my spouse's employer's plan or have other insurance).

Section VIII. Salary Redirection Agreement Section

This section pertains to the Flexible Spending Account (FSA). If you did not elect the FSA option then leave this section blank. If you did choose to have pretax dollars set aside this section gives authorization for your employer to deduct these contributions from your earnings.

Section IX. To be Completed By Employee's Church Section

Please have your church payroll/contact person fill out and sign this section. We need this information for disability coverage purposes. We need to know total compensation in order to accurately determine the level of disability coverage.

At the end of this package you will also find an "ACH Process Form" authorizing Tri-Star Benefits to electronically receive payment for the premium(s) due. Please give this form to your church payroll/contact to fill out and sign.



Office Use Only	
Division ID _____	Department _____
Class ID _____	PW _____
Routing Account No _____	
Effective Date _____	

BENEFITS ENROLLMENT FORM

I. Employee Information Section

Employee Name (Last, First, MI): _____

Address (Street, City, State, Zip): _____

Phone: _____ **Cell Phone:** _____ **Email:** _____

SSN: _____ **Date of Birth:** ____/____/____ **Age:** _____

Gender: male female **Marital Status:** single married **Covered by Medicare:** yes no **Tobacco Use:** yes no

Date of Hire: ____/____/____ **Occupation:** _____ **Annual Salary:** _____

Spouse Name (Last, First, MI): _____ **DOB:** ____/____/____ **SSN:** _____

Dependent Name: _____ **DOB:** ____/____/____ **SSN:** _____

Dependent Name: _____ **DOB:** ____/____/____ **SSN:** _____

Dependent Name: _____ **DOB:** ____/____/____ **SSN:** _____

Dependent Name: _____ **DOB:** ____/____/____ **SSN:** _____

Dependent Name: _____ **DOB:** ____/____/____ **SSN:** _____

Attach additional sheets as necessary

II. Church Information Section

Church Name: _____ **Church Synod:** _____

Church Address (Street, City, State, Zip): _____

Church Phone: _____ **Church Fax:** _____ **Payroll/Contact Person:** _____

Church Email address: _____ **Church Website:** _____

III. Beneficiary Information Section

Beneficiary Name (Last, First, MI): _____ **DOB:** ____/____/____ **SSN:** _____

Relationship: _____ **Percentage:** ____% **Primary/Contingent:** Primary Contingent

Beneficiary Name (Last, First, MI): _____ **DOB:** ____/____/____ **SSN:** _____

Relationship: _____ **Percentage:** ____% **Primary/Contingent:** Primary Contingent

Beneficiary Name (Last, First, MI): _____ **DOB:** ____/____/____ **SSN:** _____

Relationship: _____ **Percentage:** ____% **Primary/Contingent:** Primary Contingent

Beneficiary Name (Last, First, MI): _____ **DOB:** ____/____/____ **SSN:** _____

Relationship: _____ **Percentage:** ____% **Primary/Contingent:** Primary Contingent

Attach additional sheets as necessary





Office Use Only	
Division ID _____	Department _____
Class ID _____	PW _____
Routing Account No _____	
Effective Date _____	

IV. Benefit Elections Section

- Medical Coverage:** Employee Employee/Spouse Employee/Child(ren) Family
- I am declining Medical coverage for myself because I have Medicare, but I would like to elect coverage for my: Spouse Child(ren)
- Dental* Coverage**:** Employee Employee/Spouse Employee/Child(ren) Family
- Vision Coverage**:** Employee Employee/Spouse Employee/Child(ren) Family

*Persons opting out of Dental Coverage will not be eligible to enroll for three years from the date of this application.

**When selected, Dental and Vision Coverage must be same type as Medical (unless Employee is covered under Medicare).

Flexible Spending Account:

- Benefit Types:** Health Flexible Spending Account Plan (not to exceed \$2400/year) \$ _____ annual
- Dependent Care Account (not to exceed \$2400/year per family) \$ _____ annual
- Transportation Account (not to exceed \$200/month for Trans. & Parking combined) \$ _____ annual
- Parking Account (not to exceed \$200/month for Trans. & Parking combined) \$ _____ annual

Payroll Interval: Weekly Every two weeks Twice a month Monthly

Please indicate your payroll interval, the benefit(s) in which you would like to participate, and the annual deductions to be taken for each benefit type below. This amount will be pro-rated in the case of a short plan year:

Additional Options Available through Hahn Financial Group (please check if you would like to be contacted about these options):

- Additional \$100,000 Guaranteed Issue Life Insurance Additional \$10,000 Guaranteed Issue Critical Illness Insurance
- Additional Voluntary Life Insurance for Self/Spouse/Dependents Additional Critical Illness Insurance for Self/Spouse/Dependents Voluntary Accident Expense Insurance for Self/Spouse/Dependents

V. Special Benefit Elections if Husband/Wife are both eligible employees

My spouse carries Family coverage through this plan, so I am declining Medical/Dental/Vision coverage. Please enroll me as Employee-only in the Life, AD&D, Disability and Critical Illness package policy.

Additional Options Available through Hahn Financial Group (please check if you would like to be contacted about these options):

- \$100,000 Guaranteed Issue Life Insurance \$10,000 Guaranteed Issue Critical Illness Insurance
- Additional Voluntary Life Insurance for Self/Spouse/Dependents Additional Critical Illness Insurance for Self/Spouse/Dependents Voluntary Accident Expense Insurance for Self/Spouse/Dependents

Your coverage is effective the first of the month after date of enrollment. You have 90 days from the date of hire to complete the enrollment. If you do not enroll within 90 days of hire, then you will not be eligible for health insurance for one year (three years for dental), and the effective date will be the first of the month after the one year (three years for dental) waiting period. The only exception is if you become eligible due to a Qualifying Life Event. Please note that the initial open enrollment is an information-only enrollment. If you choose coverage during subsequent enrollments, proof of credible coverage will be required.





Office Use Only	
Division ID _____	Department _____
Class ID _____	PW _____
Routing Account No _____	
Effective Date _____	

VI. Change of Coverage Section (Qualifying Events)

Event(s) or Reason(s) for Change: Marriage Death Divorce Birth/Adoption Change of Spouse's Employment

Other: _____ Date of Event: ____/____/____

VII. Declination of Coverage Section

Medical, Life, Disability, Critical Illness Dental Vision

Health Flexible Spending Account Dependent Care Account Transportation and Parking Account

If you wish to decline coverage, please check the benefit(s) above that you are declining, complete the sentence below and sign.

I am declining coverage because: _____

If you are declining enrollment, you may be able to enroll in the future, provided that you request enrollment within 31 days after experiencing a life/family status Qualifying Event. Qualifying Events include, but are not limited to, employment status changes, marriage, divorce, or a change in the number of dependents.

Signature of Employee (Required if you are declining coverage) _____
Date

VIII. Salary Redirection Agreement

I have read and understand the explanation I received regarding my options under the Lutheran Core Section 125 Plan. I understand my enrollment in the Health Flexible Spending Account, Dependent Care Account and/or Transportation and Parking Account is voluntary. I acknowledge that my election is irrevocable, unless there is a change in my life/family status, and will remain in force through the plan year. A change in life/family status includes, but is not limited to, employment status changes, marriage, divorce, or a change in the number of dependents. I also understand that I will forfeit any unused amount(s) in my account(s) at the end of each plan year.

I authorize my employer to deduct from my earnings my contributions for the benefits under this plan and to remit such sums to the administrator on my behalf. I further authorize my employer to deduct from my earnings any unauthorized expenses reimbursed to me by this plan.

Signature of Employee _____
Date

IX. This Section To Be Completed by Employee's Church

Please enter the amount that the Church contributes in each category towards the employee's total compensation package.

W-2 or 1099 Annual Salary: _____ Retirement Account Contribution: _____

Section 107 (housing allowance): _____ Housing Equity Account Contribution: _____

Health Insurance Premium Paid: _____

Signature of payroll/contact person _____
Date



ACH Process Form

Church Name: _____

Effective Date: _____

Funding Required for the Administrative Fees

TRISTAR Benefit Administrators will email your company the administrative fees payment due. TRISTAR Benefit Administrators will ACH transfer the premium payment the 25th of the month from your designated bank account. Please complete the Banking Information section.

Banking Information

Account Name: _____

Account Number: _____

Account Type: _____

Routing Number: _____

***Please attach a voided check**

Bank Name: _____

Bank Address: _____

Bank Phone Number: _____

**** Please attach a copy of a cancelled check ****

I hereby authorize TRISTAR Benefit Administrators to process funds based on the information above.

Print Name

Date

Signature

Date

Document Checklist & Submission Instructions

Step 1. Fax

1. Completed and signed Health "Enrollment Form" (2 pages)
2. Completed and signed "Benefits Enrollment Form" (3 pages)
3. Church "ACH Process Form"

Fax all documents to:
Hahn Financial Group, Inc.
Attention: Lutheran Benefits Enrollment
(605) 275-9595

After faxing go to step 2.

Step 2. Mail

1. Completed and signed Health Enrollment Form
2. Completed and signed Benefits Enrollment form
3. Church ACH Form
4. Photocopy of Marriage Certificate (if applicable)
5. Photocopy of Birth Certificate(s) (if applicable)
6. Photocopy of proof of prior dental coverage (i.e. card or statement)
7. Signed "Authorization and Membership Rights Notice" (separate attachment)

Mail all original documents to:
Hahn Financial Group, Inc.
Attention: Lutheran Benefits Enrollment
3101 S. Phillips Ave.
Sioux Falls, SD 57110

If you have more questions please feel free to call us at 1-800-516-HAHN (4246)
or email us at lutheranbenefits@hahnfinancialgroup.com