Continuing Coverage

FOR INTERIM ROSTERED LEADERS CALLED BY A SYNOD COUNCIL

Important Information

This form must be received by Portico Benefit Services within 60 days of your change in status. Incomplete or illegible forms may be returned.

A Member Information

Legal Name (First) | MI | Last | Member ID

Address

City | State | ZIP Code

Email Address | Date of Birth (MM/DD/YYYY) | Social Security Number XXX–XX–☐☐☐☐

ELCA Synod Affiliation

( ) Home Phone | ( ) Work Phone | ( ) Cell Phone | ( ) Fax

Legal Name of Spouse or ESGP* (First, MI, Last) | Spouse's or ESGP's Social Security Number

B ELCA Extended Benefits

1. To be eligible for coverage, I verify that I am either:

☐ Serving under call from a synod council and between assignments

☐ Going on leave from call after completing an interim call from a synod council

2. I elect to continue the following benefits at my own expense:

☐ Health benefits and basic group life insurance

☐ Disability benefit coverage (Complete Section E.)

NOTE: If you purchased supplemental or dependent life insurance, contact Minnesota Life Insurance Company at 866.293.6047 to continue this coverage.

*An eligible same-gender partner (ESGP) is an individual who satisfies Portico Benefit Services' same-gender partnership requirements as attested to on a completed *Affidavit of Partnership* filed with Portico.

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C ELCA Health Benefits Plan Coverage Election

1. Select your ELCA Health Benefits Plan option (check [✔] all that apply)
Sign in to myPortico for details on all health benefit options, coverage continuation costs, and information on health savings account contributions (Silver+ and Bronze+ options only).

☐ I elect the following ELCA-Primary health benefit option for all covered family members not eligible for Medicare:

☐ Platinum+ ☐ Gold+ ☐ Silver+ ☐ Bronze+

☐ I am eligible for Medicare.

2. List yourself and all eligible dependents who will have ELCA health coverage. Children under age 26 are eligible for the ELCA health benefit. (Attach a separate sheet of paper if more space is needed.)

Member's Name	Social Security Number	Gender (F or M)	Birth Date (MM/DD/YYYY)	**Is individual enrolled in Medicare Part A/B?**
				☐ Yes ☐ No
Spouse's/ESGP's Name	– –			☐ Yes ☐ No
Child's Name	– –			☐ Yes ☐ No
Child's Name	– –			☐ Yes ☐ No

3. To waive ELCA health coverage, you are required to have other valid health coverage; either employer-provided group health coverage or individual coverage purchased through a health insurance exchange for which you received a premium tax credit (subsidy).

Family members covered under other valid coverage (check [✔] one):

☐ Entire Family ☐ Member Only ☐ Spouse Only ☐ Child(ren) Only ☐ Spouse and Child(ren)

4. If waiving coverage, provide the following information about your other valid coverage; either employer-provided group health coverage or individual coverage purchased through a health insurance exchange for which you received a premium tax credit (subsidy):

☐ **Employer-provided coverage:**

Name of Employer Providing Coverage **(Required)** | ID Number | Group Number

Name of Health Insurance Company **(Required)** | Phone

☐ **Subsidized exchange coverage:**

Name of State Exchange **(Required)** | Name of Insurance Company **(Required)**

ID Number | Exchange Phone

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D Signature of Member

I understand that to continue ELCA benefits coverage, I must enroll in the benefits indicated in Section B within 60 days of ending an assignment where my employer sponsored me in the ELCA benefits program. I understand coverage starts the day after this assignment ended.

Additionally, I acknowledge:

- I must pay the cost of benefits elected if I'm not sponsored in the ELCA benefits program by an eligible employer.
- My family and I may waive ELCA health coverage if we have other valid coverage.
- My family and I may waive coverage and (re)activate ELCA health coverage on a later date. If ELCA health coverage is activated more than 60 days following termination of the other valid coverage, I (we) will be subject to a 90-day waiting period for ELCA health coverage.

Signature of Member (**Required**) Date (MM/DD/YYYY)

E Signature of Bishop (required for disability coverage)

I certify this pastor or rostered layperson has been serving under a synod council call to interim ministry.

Name of Calling ELCA Synod

Signature of Bishop or Bishop's Representative (**Required**) (MM/DD/YYYY)

Return this completed form to the Portico Service Center. Incomplete or illegible forms may be returned.

Portico Benefit Services
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