



RETIREMENT MEMBERSHIP APPLICATION
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 2561 (Rev. 12-2014)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A MEMBER INFORMATION	
Name (Last, First, Middle)	NDPERS Member ID
Last 4 Digits of Social Security Number	Date of Birth (MO/DAY/YR)
Organization Name	NDPERS Organization ID

PART B DUAL RETIREMENT MEMBERSHIP
Are you a member of the following retirement plans? <input type="checkbox"/> North Dakota Teachers Fund for Retirement (NDTFFR): Employer _____ From _____ To _____ <input type="checkbox"/> Teachers Insurance & Annuity Association College Retirement Equities Fund (TIAA-CREF)-coverage through the ND University System: Employer _____ From _____ To _____

PART C IMPORTANT NOTICES
<p>Section 1: All eligible employees of a participating employer must be immediately enrolled in the NDPERS Defined Benefit plan unless you previously elected participation in the NDPERS Defined Contribution plan. If you previously participated in the NDPERS Defined Contribution plan, you will remain a participant in the Defined Contribution plan.</p> <p>If you are a permanent state employee you have 6 months from taking your new position to switch from the Defined Benefit Plan to the Defined Contribution Plan. If you elect to participate in the Defined Contribution Plan, you do not have the option to switch back to the Defined Benefit Plan. If you wish to elect to participate in the Defined Contribution Plan, you will be provided a "DEFINED CONTRIBUTION RETIREMENT PROGRAM ELECTION SFN 52170". Your election is irrevocable.</p> <p>Section 2 In accordance with the North Dakota Century Code Chapter 15-39.01-09(3), if you are certified to teach in the state by the Education Standards and Practices Board and first employed and entered upon the payroll of the Department of Career and Technical Education after July 1, 2007, you may elect within 90 days from date of hire to become a member of the Public Employees Retirement System or the Teachers' Fund for Retirement. If an election is NOT made within 90 days from the date of hire, you will be transferred to the Teacher's Fund for Retirement. Additional funds will also be required to make up the employee contribution rates. Complete an "NDPERS/TFFR MEMBERSHIP ELECTION SFN 52727". Your election is irrevocable.</p> <p>Section 3 In accordance with the North Dakota Century Code Chapter 15-39.01-09(3), if you are certified to teach in the state by the Education Standards and Practices Board and first employed and entered upon the payroll of the Department of Public Instruction after January 6, 2001, you may elect within 90 days from date of hire to become a member of the Public Employees Retirement System or the Teachers' Fund for Retirement. An election made under North Dakota Century Code Chapter 15-39-1-09(3) is irrevocable. If an election is NOT made within 90 days from the date of hire, you will be transferred to the Teacher's Fund for Retirement. Additional funds will also be required to make up the employee contribution rates. Complete an "NDPERS/TFFR MEMBERSHIP ELECTION SFN 52727". Your election is irrevocable.</p>

PART D MEMBER AUTHORIZATION
In accordance with the requirements of the North Dakota Public Employees Retirement System, I make application for retirement enrollment. I understand that my membership will become effective immediately or at the attainment of age 18. I declare that the foregoing statements are full, true, and correct to the best of my knowledge and belief, and are subject to the laws and penalties governing any misrepresentation and fraud. <u>Submit a "Designation of Beneficiary SFN 2560" along with this form.</u>
<p>_____</p> <p>Member's Signature</p> <p>_____</p> <p>Date of Signature</p>

PART A: MEMBER INFORMATION

For member identification, please provide all requested information.

PART B: DUAL MEMBERSHIP

Indicate if you have membership with the North Dakota Teachers Fund for Retirement (NDTFFR) or Teacher Insurance & Annuity Association-College Retirement Equities Fund (TIAA-CREF- ND Board of Higher Education) and the dates of employment and the employer's name.

PART C: IMPORTANT NOTICES

If you are a permanent state employee, please ensure that you carefully reads Section 1; this pertains to participation in the Defined Contribution plan versus the Defined Benefit plan.

If you are a certified teacher and are employed with either the Department of Career and Technical Education or the Department of Public Instruction, please ensure that you carefully read Sections 2 and 3; this pertains to your participation in NDPERS or the NDTFFR.

PART C: MEMBER AUTHORIZATION

You must sign and date the form. Your signature should reflect the name as entered in Part A. Submit a "Designation of Beneficiary SFN 2560" along with this form.

Please review form before submitting to NDPERS to ensure that ALL appropriate sections/boxes are complete.



DESIGNATION OF BENEFICIARY FOR THE GROUP RETIREMENT PLAN

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 2560 (Rev. 03-2016)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

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(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920**

PART A MEMBER INFORMATION					
Name (Last, First, Middle)			<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		NDPERS ID
Date of Birth		Last Four Digits of Social Security Number			
Spouse Name (Last, First, Middle)			Spouse Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
PART B PRIMARY BENEFICIARY (IES) – Complete all sections					
Name	Relationship	Social Security Number	Birth Date	% Share	Address
Total must equal				100%	
PART C CONTINGENT/SECONDARY BENEFICIARY(IES)					
Name	Relationship	Social Security Number	Birth Date	% Share	Address
Total must equal				100%	
PART D MEMBER AUTHORIZATION					
I understand that this election revokes any previous retirement account beneficiary designations. I understand that, if married, any initiation of dissolution or annulment of my marriage may void this designation. I have read and understand the terms and conditions listed on page two (2) of this designation. I hereby certify that the information provided on this form is true and correct to the best of my knowledge.					
_____			_____		
Member Signature			Date of Signature		
PART E SPOUSE AUTHORIZATION					
IF YOU ARE MARRIED AND DESIGNATE A BENEFICIARY OTHER THAN OR IN ADDITION TO YOUR SPOUSE, YOUR SPOUSE MUST COMPLETE THIS SECTION					
If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to the listed beneficiary (ies).					
If a member with three or more years of credited service is married, North Dakota law requires the spouse's* consent before benefits can be paid other than to the member's spouse*. (NDCC 30.1-05-02). If spouse's* consent is given, please be advised, that if your primary beneficiary election is someone in addition to or in lieu of your spouse, there is no monthly pre-retirement death benefit provision.					
I consent to the above retirement beneficiary (ies) designated by the above named NDPERS member.					
_____			_____		
Spouse Signature			Date of Signature		

PROVISIONS FOR ALL BENEFITS

1. This "Designation of Beneficiary" is for the group Retirement Plan only. To designate beneficiary (ies) for the group Life Insurance Plan, please complete a "Life Designation of Beneficiary SFN 53855".
2. **EFFECTIVE WHEN FILED:** This designation will be effective when properly executed and received in the NDPERS office.
3. **SUBJECT TO LAWS AND REGULATIONS:** This designation is subject to the governing statutes and to rules and regulations established by the Retirement Board of the North Dakota Public Employees Retirement System. The acceptance of the designation by NDPERS does not establish that a survivor benefit will be payable. Whether or not a benefit is payable and the amount thereof will be determined at the time of death under laws and regulations then applicable.
4. **WHO IS ELIGIBLE TO BE A BENEFICIARY:** Any person, whether or not a relative, or a church or charity may be designated as a primary or contingent beneficiary. A member may also designate his or her estate as beneficiary and the benefits will be distributed according to his or her testamentary will or according to the state laws for interstate distribution. A creditor of a member (such as a bank, credit union, loan company, etc.) may not be named a beneficiary as a means of providing security for a debt. (N.D.C.C. 28-22-19)
5. **DESIGNATED BENEFICIARIES:** All beneficiary designations shall equal 100% of the benefit. If the benefit is being divided amongst multiple beneficiaries and the total share does not equal 100%, NDPERS shall amend the designations in order to reach the 100% in total, but in no circumstance will PERS amend the beneficiary designation by more than one (1) %. If an amendment is necessary, the additional percentage shall be credited to the eldest beneficiary.

If shares are not designated, NDPERS will distribute benefits equally to the named beneficiary (ies). As this distribution may not reflect the member's preference, we recommend the member be sure to designate the percent of share for each listed beneficiary.

6. If there are no surviving beneficiaries, all benefits will be paid to your estate.
7. A **certified** copy of the death certificate must be sent to NDPERS to process a claim.

PROVISIONS FOR RETIREMENT BENEFITS ONLY

1. **DEATH OF ACTIVELY EMPLOYED MEMBER:**
 - A. If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to whoever is the listed beneficiary(ies).
 - B. If a member dies after completing three years of service, his/her retirement account will be distributed pursuant to N.D.C.C. 54-52-17(6) and N.D.C.C. 39-03.1-11(6).
2. **DEATH OF RETIREE:** Benefits will be paid to the named beneficiary based upon the option selected by the member at retirement. If there are no surviving beneficiaries, any remaining cash value will be paid to your estate.
3. **DEATH OF SURVIVING SPOUSE (in accordance with North Dakota law):** A lump sum payment of any remaining cash value will be paid to the spouse's named beneficiary. If there are no surviving beneficiaries, any remaining cash will be paid to the spouse's estate.

<p>NOTE: Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established.</p>



AGREEMENT/WAIVER OF PARTICIPATION FOR OPTIONAL DEFINED BENEFIT RETIREMENT PLAN

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 17627 (Rev. 06-2015)

**NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920**

PART A EMPLOYEE INFORMATION	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID

PART B EMPLOYEE ACKNOWLEDGEMENT	
INITIAL ALL BOXES – REQUIRED	
	I am an employee of a participating governmental unit and am filling a position that is not regularly funded or if it is regularly funded, I do not work twenty (20) or more hours a week for more than 19 weeks a year. My services may or may not be limited in duration.
	I understand that I can only elect to participate in the NDPERS as a temporary/part-time employee within the first six months of employment or within six months of a change in status from permanent/full time to temporary/part-time.
	I understand that I can not elect to participate in the North Dakota Public Employees Retirement System as a temporary/part-time employee if I am actively contributing to another employer sponsored Pension fund (Public or Private).
	I understand that upon electing to participate in the North Dakota Public Employees Retirement System, I will be obligated to contribute monthly contributions to the plan and do not have access to these funds for any reason while I am employed with the state of North Dakota or political Subdivision.
	I acknowledge that the monthly after tax contribution I am obligated to pay is 15.26% of my gross monthly salary and this contribution must be submitted to my payroll officer no later than the 6th working day of the month for the previous month's salary.
	I understand that if I miss a payment of my retirement contribution to NDPERS for any reason other than an approved Leave of Absence, I will have thirty (30) days to bring my account up to date. Failure to do so will result in termination of my eligibility to participate for the remainder of the plan year as a temporary/ part-time employee.
	I understand that if I terminate my employment and take a refund of my retirement monies, I will not be allowed to participate in NDPERS through future employment as a temporary/part-time employee.
	I acknowledge that I cannot participate as both a temporary employee and a permanent employee. In the event that my employment qualifies me for participation as a full-time permanent employee, I must participate as such. Additional part-time employment cannot be included.

PART C AGREEMENT TO PARTICIPATE	
IF YOU ELECT TO PARTICIPATE: I understand the statements listed in Part B and certify that I am eligible under NDCC 54-52-02.9 to participate in the North Dakota Public Employees Retirement System. I elect to begin participating in the system effective _____.	
_____	_____
Signature of Applicant	Date
_____	_____
Signature of Authorized Agent	Date
FOR PERSONS WHO ELECT TO PARTICIPATE, THIS FORM MUST BE ACCOMPANIED BY A MEMBERSHIP ENROLLMENT FORM (SFN 2561) AND A DESIGNATION OF BENEFICIARY FORM (SFN 2560) TO BE VALID.	

PART D WAIVER OF PARTICIPATION	
IF YOU DECLINE TO PARTICIPATE: I understand the statements listed in Part B and certify that I am eligible under NDCC 54-52-02.9 to participate in the North Dakota Public Employees Retirement System. I decline to participate.	
_____	_____
Signature of Applicant	Date

INSTRUCTIONS

PART A: EMPLOYEE INFORMATION

For member identification, please provide all requested information.

PART B: EMPLOYEE ACKNOWLEDGEMENT

Complete the following whether the employee is electing to participate or declining to participate in the Defined Benefit retirement plan. The employee must read each paragraph and indicate acknowledgement by initialing all boxes on the left side.

PART C: ELECTION TO PARTICIPATE AGREEMENT

(This section should be completed only if employee wishes to participate in optional Defined Benefit retirement program).

1. The Authorized Agent must fill in the effective membership date.
2. The employee must sign and date the form. The employee's signature must reflect the name as entered in Part A.
3. The department's authorized agent must sign and date the form.
4. This signature line will be signed and dated by authorized NDPERS staff and a copy will be mailed back to the department.

If steps 1 through 4 are not completed, the form will be returned. To be valid the form must also be accompanied by a Retirement Membership Application SFN 2561.

PART D: WAIVER OF PARTICIPATION

The employee must sign and date this section only if the employee waives participation in the Defined Benefit retirement plan.

Section 3 Level Of Coverage for Plan:

- Single Coverage (Self Only)
 Family Coverage (Self and Spouse OR Self and Eligible Child(ren) OR Self, Spouse, Eligible Child(ren))

PART C DEPENDENT INFORMATION

1. List all family members to be covered under the plan indicated in Part B, Section 1, other than yourself.
 - a. Indicate dependent's address below name if address is different from yours.
 - b. For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
 - c. For Marital Status, enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed
2. If your marital status is single and you are applying for family coverage, you are required to attach a copy of the state birth certificate for each Eligible Dependent unless previously submitted.
3. If you are adding a grandchild, a Grandchild Eligibility Verification SFN 60983 must be submitted also, along with a copy of the child's birth certificate.

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Section 3402. The individual's social security number will be used for tax reporting and as an identification number.

Dependent Name (last, first, middle) If address is different then subscriber, indicate address under name	Relationship	Gender	Date of Birth	Social Security Number	Marital Status	Court Ordered Coverage	Active Military
	Spouse					N/A	<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

PART D MEDICARE COVERAGE INFORMATION

Are you or spouse or any of your Eligible Dependents currently covered by Medicare?

- No, skip to next section Yes, complete the following:

Are you or spouse or any of your Eligible Dependents currently covered by Medicare due to End Stage Renal Disease?

- No, skip to next section Yes, complete the following:

Individual on Medicare (Last, First, Middle)	Medicare Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date

PART E OTHER COVERAGE INFORMATION

Are you, your spouse or any of your Eligible Dependents currently or were previously covered by another insurance benefit plan(s), **INCLUDING NDPERS BENEFIT PLAN(S)**? No, skip to next section Yes, **please complete this section AND attach Certificate(s) of Coverage or other documentation from your insurance company. Failure to provide documentation may affect your waiting period.**

Other Coverage Name & Phone Number	Policy Number	Policyholder (last, first, middle)	Date of Birth	Policy Coverage Dates (mm-dd-yy)	Name(s) of Person(s) Covered
				From:	
				To:	
				From:	
				To:	

Do you intend to keep your current policy (ies) in force after the effective date of this Application?

- Yes No, Why? _____

Workers' Compensation/No-Fault

Are you, your spouse or any of your Eligible Dependents currently receiving or have received worker's compensation benefits? No Yes
 Are you, your spouse or any of your Eligible Dependents currently receiving no-fault benefits? No Yes

Person's Name	Injury Date (MM-DD-YY)	Type of Injury	Company Providing Benefits & Phone Number

PART F EMPLOYER CERTIFICATION OF ACA ELIGIBLE TEMPORARY EMPLOYEE

I certify that this employee meets the definition of a full-time employee under the Affordable Care Act and as such, is being offered coverage. Check appropriate method of determination:

Monthly Measurement
 Date of New Hire: ____/____/____ **Date of Change in Position/Increase in Hours:** ____/____/____

Look-back Measurement
 The current measurement period used by the employer is: From:____/____ To:____/____
 This information is required for NDPERS to determine enrollment eligibility.

_____ _____
 Authorized Agent's Signature Date of Signature

PART G MEMBER AUTHORIZATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (front and back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively cancelling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

- I understand members are subject to limitations and exclusions outlined in the relevant Benefit Plan/Policy.
- I understand that in the event the group through which I am enrolled elects to terminate, the Insurance Carrier has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.
- I understand conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with the Insurance Carrier and has enrolled as a group with another Insurance Carrier.
- I understand, in the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit to NDPERS.
- I acknowledge that the Summary of Benefits and Coverage and other related plan information is available on the NDPERS website at www.nd.gov/ndpers.

Please retain a copy of this Application for your records

_____ _____
 Member's Signature Date of Signature

PART D OTHER COVERAGE INFORMATION

Are you, your spouse or any of your Eligible Dependents currently or were previously covered by another insurance benefit plan(s), **INCLUDING NDPERS BENEFIT PLAN(S)**? No, skip to next section Yes, **please complete this section AND attach Certificate(s) of Coverage or other documentation from your insurance company. Failure to provide documentation may affect your waiting period.**

Plan**	Other Coverage Name & Phone Number	Policy Number	Policyholder (last, first, middle)	Date of Birth	Policy Coverage Dates (mm-dd-yy)	Name(s) of Person(s) Covered
					From: To:	
					From: To:	

****For Plan, indicate type of coverage -- Dental, or Vision**

Do you intend to keep your current policy(ies) in force after the effective date of this Application?

Yes No, Why? _____

Workers' Compensation/No-Fault

Are you, your spouse or any of your Eligible Dependents currently receiving or have received worker's compensation benefits? No Yes
 Are you, your spouse or any of your Eligible Dependents currently receiving no-fault benefits? No Yes

Person's Name	Injury Date (MM-DD-YY)	Type of Injury	Company Providing Benefits & Phone Number

PART E MEMBER AUTHORIZATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (front and back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively cancelling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

- I understand members are subject to limitations and exclusions outlined in the relevant Benefit Plan/Policy.
- I understand that in the event the group through which I am enrolled elects to terminate, the Insurance Carrier has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.
- I understand conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with the Insurance Carrier and has enrolled as a group with another Insurance Carrier.
- I understand, in the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit to NDPERS.
- I acknowledge that the Summary of Benefits and coverage and other related plan information is available on the NDPERS website at www.nd.gov/ndpers.

Please retain a copy of this Application for your records

_____ Member's Signature

_____ Date of Signature



WAIVER OF INSURANCE COVERAGE
 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
 SFN 58819 (Rev. 12-2014)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A EMPLOYEE IDENTIFICATION	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID
PART B WAIVER OF INSURANCE COVERAGE	
Check the applicable insurance plan:	
<input type="checkbox"/> Health Insurance (Use this waiver form only if the employee is eligible for health insurance coverage but does not meet the definition of a "full-time" employee as defined in the Affordable Care Act ACA)	
<input type="checkbox"/> Dental Insurance <input type="checkbox"/> Vision Insurance <input type="checkbox"/> Life Insurance	
I have been informed that I am eligible to apply for insurance coverage under my employer's Benefit Plan issued I do not wish coverage for:	
<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Eligible Dependents <input type="checkbox"/> Myself and Entire Family	
Reason coverage is being waived:	
<input type="checkbox"/> I have coverage through my spouse's or parent's employer <input type="checkbox"/> I have other individual coverage <input type="checkbox"/> I have Medicare coverage <input type="checkbox"/> Other: _____	
PART C EMPLOYEE AUTHORIZATION	
I hereby forfeit insurance coverage at this time. I fully understand that if I or my Eligible Dependents desire to be covered under my employer's insurance Benefit Plan in the future, I and my Eligible Dependents may have a Waiting Period for Preexisting Conditions and one of the following must apply:	
1. If at the time I am declining coverage, it is because:	
a. I or my Eligible Dependents have other group insurance coverage, and that coverage is either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours) or employer contributions toward such coverage was terminated; or b. Coverage was under COBRA at the time I declined coverage and that coverage has been exhausted.	
Under (a.) and (b.) above, I must complete a membership application within 31 days after I lose my current coverage.	
2. If I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may enroll myself and my Eligible Dependents, provided that I request enrollment within 31 days of marriage, birth, adoption or placement for adoption.	
3. If I do not meet requirements under 1 or 2 above, I may apply as a Late Enrollee, Late Enrollees must request enrollment during the Enrollment Period.	
_____	_____
Employee's Signature	Date



LIFE INSURANCE ENROLLMENT/CHANGE
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53803 (Rev. 03-2016)

Underwritten by Voya Financial (Carrier) Policy Number: 67389-7

PART A EMPLOYER/EMPLOYMENT STATUS

Organization Name	NDPERS Organization ID	Employment Status <input type="checkbox"/> Active Full-Time <input type="checkbox"/> Active Part-Time
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This Change is due to: (Check all that apply) <input type="checkbox"/> New Hire (Date of Hire ____/____/____) <input type="checkbox"/> Annual Enrollment-Read below for Evidence of Insurability (EOI) requirements <input type="checkbox"/> Decrease Coverage <input type="checkbox"/> Marital Status Change (Date of Change ____/____/____) <input type="checkbox"/> Birth/Adoption (Date of Change ____/____/____)	Effective Date ____/01/20____
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PART B EMPLOYEE INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
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Last 4 Digits of SSN	Date of Birth
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PART C EMPLOYEE COVERAGE

Basic Life Employee Only—Employer Provides \$3,500 of Basic Life Coverage at no expense to you

Supplemental Life and AD&D Election: When you are first eligible for supplemental life coverage, you can elect up to the Guaranteed Issue (GI) Limit of \$200,000 without providing evidence of insurability. Upon qualifying event or annual enrollment, you can increase your employee supplemental by a \$5,000 increment without Evidence of Insurability form (EOI). Evidence of Insurability form (EOI) must be completed for amounts larger than \$5,000 and approved by the Carrier.

I am applying for a TOTAL supplemental life coverage of: \$_____. (Increments of \$5,000) Waive Additional Supplemental Life & AD&D coverage

PART D DEPENDENT COVERAGE

Supplemental Dependent Life Insurance Election: Only available if you elected Supplement in Part C. When you are initially eligible for dependent coverage, you can elect it without providing evidence of insurability. Upon qualifying event or annual enrollment, an Evidence of Insurability form (EOI) must be completed for approval by the Carrier.

\$5,000 for eligible spouse and \$5,000 for each eligible dependent child. **OR** \$2,000 for eligible spouse and \$2,000 for each eligible dependent child.
 Waive Supplemental Dependent Coverage

PART E SPOUSE COVERAGE

Supplemental Spouse Life Election: Only available if you elected dependent coverage of \$2,000 or \$5,000 in Part D. When you are initially eligible for supplemental spouse coverage, you can elect up to \$50,000 in coverage without providing evidence of insurability. Total spouse coverage up to \$100,000 is available if your spouse completes an Evidence of Insurability form (EOI) for approval by the Carrier. **Supplemental spouse coverage is limited to 50% of the employee's coverage amount.** Upon a qualifying event or annual enrollment, an Evidence of Insurability form (EOI) must be completed.

Total Amount of coverage \$_____ (Increments of \$5,000) Name _____ Date of Birth ____/____/____
 Waive Supplemental Spouse Coverage

PART F BENEFICIARY INFORMATION

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855

PART G AUTHORIZATION

READ THIS INFORMATION CAREFULLY AND PLEASE SIGN THIS FORM BEFORE SUBMITTING IT TO YOUR PAYROLL OFFICE

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by the Carrier, provided I am actively at work.
- I understand that evidence of insurability may be required for coverage to become effective.

_____	_____
Employee's Signature	Date

Part A Employer/Plan Sponsor

Must be completed by your employer's authorized agent.

Part B Employee Information

For member identification, please provide all requested information.

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage. Indicate the TOTAL amount of coverage you are requesting.

YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part C Employee Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage. Indicate the TOTAL amount of coverage you are requesting.

YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE. Upon Retirement, Basic Life will be decreased to \$1,300.

Part D Dependent Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.
YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part E Spouse Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.
YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE

Part F Beneficiary Information

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855.
IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part G Authorization

You must sign and date this section for this form to be valid.

EVIDENCE OF INSURABILITY (ND)

ReliaStar Life Insurance Company, Minneapolis, MN
 A member of the Voya family of companies
 PO Box 20, Mail Stop 4-S, Minneapolis, MN 55440
 Phone: 612.342.7262 Fax: 612.467.8721



Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number 673897 Account Number 1 Employer Name NDPERS
 Option 1 _____ Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Address _____ City _____ State _____ ZIP _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Hire Date _____ Salary \$ _____ Occupation _____
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS (Complete this table based only on the coverage you have through this plan.)

Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.)? Yes No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) - (B) - (C) = Amount To Be Underwritten
<input type="checkbox"/> Employee Supplemental Life	\$	\$	\$	\$
<input type="checkbox"/> Spouse Supplemental Life	\$	\$	\$	\$
<input type="checkbox"/> Dependent Spouse Supplemental Life	\$	\$	\$	\$
<input type="checkbox"/> Dependent Children Supplemental Life (per child)	\$	\$	\$	\$

C. SPOUSE INFORMATION

Spouse Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Same Primary Health Practitioner as Employee (See information above.)
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

D. CHILD INFORMATION (Availability of Child coverage is dependent on plan rules and may also be dependent on approved employee coverage. If more than 3 children, list information on additional sheet.)

Name (First, MI, Last)	Birth Date	Gender	Relationship
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent Children Health Questions (Answer these questions only if applying for dependent child(ren) coverage.)

1. Within the past 5 years, have any dependent children been treated for or diagnosed with a mental or nervous disorder (excluding ADHD), diabetes, heart disorder, cancer, asthma (requiring hospitalization within the last 2 years), or chemical abuse? Yes No
2. Do any dependent children have cerebral palsy, cystic fibrosis, muscular dystrophy, developmental disorder (including Autism and Down's Syndrome), or complications associated with premature birth? Yes No

For each "Yes" answer, provide name(s) of child(ren) and details. _____

Employee Name _____ SSN (Last 4 digits only) _____

E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Employee (EE) Spouse (SP)
 Yes No Yes No

- 1. Have you ever been diagnosed or treated by a member of the medical profession as having AIDS, ARC, or the HIV infection?
- 2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
- Complete for EE and SP. ---> 3. **Employee:** Height _____ ft. _____ in. Weight _____ lbs. **Spouse:** Height _____ ft. _____ in. Weight _____ lbs.
- 4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
 - a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
 - b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
 - c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
 - d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
 - e. Polycystic kidney disease or kidney failure?
- 5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
 - a. Chest pain, heart trouble or circulatory disorder?
 - b. Anemia or leukemia?
 - c. Sleep apnea, asthma or other respiratory disorder?
 - d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
 - e. Stomach disorder?
 - f. Brain or seizure disorder?
 - g. Mental or nervous disorder?
 - h. Arthritis, paralysis or any muscle weakness?
 - i. Abnormal urine specimen or urinary tract disorder?
 - j. Prostate or other reproductive organ disorder?
- 6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
- 7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
- 8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
- 9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

If applying for disability income coverage, please complete this additional question:

- N/A - 10. In the past 5 years have you experienced symptoms of or been treated for arthritis, fibromyalgia, back or neck disorder, spinal disorder, joint or bone disorder, muscle disorder, carpal tunnel syndrome or chronic pain?

For every "Yes" answer, to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	

0000000000

Employee Name _____ SSN (Last 4 digits only) _____

F. AUTHORIZATION AND ACKNOWLEDGMENT (Please read and sign below)

For underwriting and claim purposes, I give my permission to any blood bank, blood center, plasma center, health care provider, any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations—42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.

I declare that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

➡ Employee Signature _____ Date _____

➡ Spouse Signature _____ Date _____

Return completed EOI to your payroll/HR Office for forwarding to NDPERS.

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya family of companies



We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.



LIFE INSURANCE DESIGNATION OF BENEFICIARY
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53855 (Rev. 01-2014)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A MEMBER INFORMATION Policy Number: 67389-7

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth

Married Single Divorced Widowed

Effective Date:

PART B DESIGNATION OF BENEFICIARY

Primary Beneficiary(ies) (If person enter: Last, First, Middle)	Relationship	Gender	Social Security Number	Birth Date	% Share	Address

Must Equal 100%

Contingent/Secondary Beneficiary(ies) (If person enter: Last, First, Middle)	Relationship	Gender	Social Security Number	Birth Date	% Share	Address

Must Equal 100%

PART C MEMBER AUTHORIZATION

I understand that this election revokes any previous life insurance beneficiary designations. I have read and understand the terms and conditions listed on page two (2) of this designation. I hereby certify that the information provided on this form is true and correct to the best of my knowledge.

Member Signature

Date Signed



Part A Member Information

Enter your name, NDPERS ID number, date of birth, last four digits of your Social Security Number, marital status, and effective date of change.

Part B Designation of Beneficiary

1. Use full legal name. (Example: "Anna May Smith," not Mrs. John Smith")
2. A member may designate contingent beneficiary (ies) who will receive benefits if the primary beneficiary (ies) predecease member.
3. If more than one person in a class (primary or contingent beneficiary) is named, members of that class will share equally in the benefits unless specific shares are designated. The total number of shares must equal 100 percent. The benefit will be distributed as directed by the designation. If a named beneficiary does not survive, the beneficiary's share will be distributed among any surviving beneficiaries, in the same proportion as the initial shares.
4. To file a death claim, a certified copy of the Death Certificate must be provided to NDPERS to process the claim.
5. Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established, or as allowed by law.
6. If an estate is named, specify whose estate such as: "Estate of the Insured." Full name and address of the executor must be included.

TRUSTEE DESIGNATION:

1. Trustee under the last will and testament of the insured, or his/her successors in trust, PROVIDED, HOWEVER, that if no claim is made by the Trustee within one year from the date of death of the insured or if the insured shall die leaving no last will and testament containing the trust covering this policy, the proceeds shall be payable to the estate of the insured. Payment of the proceeds of this policy to said Trustee or successors in trust shall fully and finally discharge the Company from all liability.
2. "The _____ Trust Company, trustee under written trust agreement date (month, date, year) _____, or its successor or successors in trust, and payment of the proceeds of this policy to said Trustee or successor or successors shall fully and finally discharge the Company from all liability." Full name and address of trust administrator must be included.

IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part C Member Authorization

You must sign and date this section for this form to be valid.


FLEXCOMP ENROLLMENT

 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
 SFN 53851 (Rev. 01-2014)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328-3900 • 1-800-803-7377 • Fax 701-328-3920

PART A EMPLOYEE INFORMATION		
<input type="checkbox"/> New Election Date of Hire: _____ To participate in the Plan for the period _____ through December 31, 20____.		
Employee Name (Last, First, Middle)		NDPERS Member Id (Required)
Employee Id (OMB & BND Payroll System-Required)	Last Four Digits of Social Security Number	Date of Birth
Organization Name		NDPERS Organization ID
PART B PREMIUM CONVERSION –DECLINE TO PRE-TAX LIFE INSURANCE PREMIUM		
Group Life Employee Supplemental Insurance Premium up to \$50,000 of coverage will automatically be pre-taxed. I decline this action.		
_____		_____
Employee's Signature		Date
PART C PREMIUM CONVERSION- PRE-TAX INSURANCE PREMIUMS		
I elect to pretax the following insurance premiums, excluding the NDPERS administered group life insurance:		
Company/Product Name		
<input type="checkbox"/> AFLAC-Accident	<input type="checkbox"/> Central United – Cancer	<input type="checkbox"/> Delta Dental - NDPERS
<input type="checkbox"/> AFLAC-Cancer	<input type="checkbox"/> Colonial Life & Accident – Accident	<input type="checkbox"/> Total Dental Admin-Elite Choice
<input type="checkbox"/> AFLAC-Hospital Confinement	<input type="checkbox"/> Colonial Life & Accident-Cancer	<input type="checkbox"/> Superior Vision - NDPERS
<input type="checkbox"/> AFLAC-Hospital Intensive Care	<input type="checkbox"/> Colonial Life & Accident-Disability	<input type="checkbox"/> Usable – Accident Elite
<input type="checkbox"/> AFLAC-Lump Sum Critical Illness	<input type="checkbox"/> Colonial Life & Accident-Medical Bridge	<input type="checkbox"/> Usable – Cancer Care Elite
<input type="checkbox"/> AFLAC-Specified Health Event Plan	<input type="checkbox"/> Conseco Health Insurance Company	<input type="checkbox"/> Usable – Hospital Confinement
<input type="checkbox"/> Custer Health Unit Only –Dental	<input type="checkbox"/> Custer Health Unit Only - Vision	
PART D MEDICAL SPENDING REIMBURSEMENT ACCOUNT		
Medical Spending Annual Maximum: \$2,500	What is the total ANNUAL amount you want payroll deducted for the Plan Year?	\$ _____ ANNUAL AMOUNT
PART E DEPENDENT CARE REIMBURSEMENT ACCOUNT		
Dependent Care Annual Maximum: Single - \$5,000 Married - \$5,000 Married filing separate tax returns - \$2,500	What is the total ANNUAL amount you want payroll deducted for the Plan Year?	\$ _____ ANNUAL AMOUNT
PART F AUTHORIZATION		
I have read the information in its entirety, INCLUDING THE BACK PAGE, and I hereby apply for the options listed above. I understand this agreement revokes my prior election. I authorize NDPERS to adjust my pay as required by my election. I understand that the benefit options I have elected will remain in force throughout the plan year unless I have a change in status event allowed under IRC Section 125. If my required contributions for the elected insurance premiums are increased or decreased while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I understand that I can not participate in the flex comp medical spending account if I am covered on the NDPERS High Deductible Health Plan (HDHP) with a Health Savings Account (HSA).		
_____		_____
Employee Signature		Date



ENROLLMENT

New employees who meet eligibility requirements must enroll within 60 days of their hire date. Your participation will begin the first day of the month the contribution is received.

ENROLLMENT FORM INSTRUCTIONS

PART A EMPLOYEE INFORMATION

For employees paid through the Office of Management and Budget (OMB) payroll system and the Bank of North Dakota: Your NDPERS Member ID is required on the form along with your Employee ID number which can be found on your pay stub or direct deposit advice.

For employees paid through their agencies payroll system: A PeopleSoft employee ID number is not required on the form.

PART B PREMIUM CONVERSION- DECLINE PRE-TAX LIFE INSURANCE PREMIUM

Your employee supplemental life insurance premium up to the first \$50,000 in coverage will automatically be pretaxed. If you wish pay the premium with after tax dollars, sign and date in Part B.

PART C PREMIUM CONVERSION- PRETAX INSURANCE PREMIUMS

Check any eligible insurance premiums you wish to have payroll deducted on a pre-tax basis.

PART D MEDICAL SPENDING REIMBURSEMENT ACCOUNT

Enter amount you want payroll deducted per pay period. Enter the number of payroll checks you will receive beginning with the first month a payroll deduction will be withheld through the end of the plan year on December 31. Multiply the amount to be deducted per pay period by the number of payroll periods in the year and enter this amount in Total Salary Redirection for the Plan Year. Your election cannot exceed the plan year maximum \$2,500.

PART E DEPENDENT CARE REIMBURSEMENT ACCOUNT

Enter the amount you want payroll deducted per pay period. Enter the number of payroll checks you will receive beginning with the first month a payroll deduction will be withheld through the end of the plan year on December 31. Multiply the amount to be deducted per pay period by the number of payroll periods in the year and enter this amount in Total Salary Redirection for the Plan Year. Your election cannot exceed the maximum limit of \$5,000 for a single parent, \$5,000 for a married couple filing a joint tax return or \$2,500 for a married person filing a single tax return.

PART F AUTHORIZATION

Sign and date the form.

RETURN FORM TO YOUR AGENCY'S PAYROLL/HUMAN RESOURCE DEPARTMENT. RETAIN A PHOTOCOPY FOR YOUR RECORDS.



457 DEFERRED COMPENSATION PLAN QUICK ENROLLMENT/WAIVER

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 54362 (Rev. 03-2016)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657

(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A EMPLOYEE INFORMATION

Name (Last, First, Middle)	NDPERS Member Id
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID

PART B QUICK DEFERRED COMP PLAN & PEP ENROLLMENT

I understand that by electing to begin participation in the 457 Deferred Compensation Plan, I will reduce my wages by \$25.00 a **month** and vest in the employer's contributions to the Defined Benefit Retirement Plan, to which I am entitled based on my service credit and level of contribution (See vesting schedule on back of form). My contributions will be invested with the NDPERS Companion Plan.

(The minimum of \$25.00 is paid at \$12.50 per pay period for bi-weekly and semi-monthly payrolls.)

I authorize my employer to reduce my salary by \$25.00 a month for pay period date beginning / / .
Month / Day / Year

Participant Authorization

Date

(This date must be in the month prior to the Beginning Date entered in above)

PART C PARTICIPANT ACKNOWLEDGEMENT

With regard to this agreement, the Participant acknowledges the following (read and initial each statement).

- ____ I understand that **by electing to participate, my salary will be reduced by \$25.00 per month.**
- ____ I understand that by participating in the deferred compensation plan and the NDPERS defined benefit retirement plan I am automatically enrolled in PEP and the applicable employer contribution is credited to my NDPERS member account.
- ____ I acknowledge that I have the right to increase or decrease the amount of contribution, change to another Provider company or suspend contributions at any time by completing the Participant Agreement for Salary Reduction form (SFN 3803).
- ____ I understand that the accumulated deferred salary is not available to me until I separate from service, or when I experience an approved unforeseeable emergency.
- ____ I acknowledge that the NDPERS Board makes no recommendation as to any fund investment and I understand that the NDPERS Board does not warrant or guarantee the investment performance of the funds offered by any provider.
- ____ I understand that all compensation deferred under the Plan, and all earnings accruing thereof, shall be held for the exclusive benefit of myself or my beneficiary, until such time as it is made available to me pursuant to the terms of the Plan.

PART D WAIVER OF PARTICIPATION

I understand that by declining to participate in the 457 Plan at this time, I **will not vest in the employer's contributions** to the Defined Benefit Retirement Plan, to which I am entitled, based on my service credit. I understand that I am eligible to begin participation at a later date and will automatically vest in the employer's contribution when I participate in a deferred compensation plan.

I elect to decline to participate at this time.

Participant Authorization

Date

This form only applies if your employer participates in the Defined Benefit Retirement Plan

By electing to enroll in the Deferred Compensation Program through your employer at a minimum required monthly contribution of \$25.00, you automatically enroll in the Portability Enhancement Provision (PEP) for the NDPERS Defined Benefit Retirement Plan. Your NDPERS retirement account will automatically be credited with the percentage of the employer contribution to which you are entitled based upon your years of credited service. As you attain additional service credit, you must increase your 457 contribution amount to the corresponding percentage of salary to achieve maximum vesting.

Service Credit	Minimum Contribution	Maximum Vesting %
0-12 Months	\$25	1%
13-24 Months	\$25	2%
25-36 Months	\$25	3%
37+ Months	\$25	4%

INSTRUCTIONS:

PART A: EMPLOYEE INFORMATION

This form must be completed regardless of whether the employee elects to participate or declines to participate in the 457 Deferred Compensation Plan and Portability Enhancement Provision (PEP).

For member identification, please provide all requested information.

Part B: QUICK ENROLLMENT IN DEFERRED COMP/PEP

This section should be completed if the employee elects to participate in the Deferred Compensation Plan and the Portability Enhancement Provision (PEP). The employee's signature in this section **will authorize** a reduction in the employee monthly wage and contribution to a deferred compensation plan. The minimum of \$25.00 is paid at \$12.50 per pay period for bi-weekly and semi-monthly payrolls.

The employee must sign and date this section. (This date must be in the month prior to the date entered above)

PART C: PARTICIPANT ACKNOWLEDGEMENT

The employee must read each item and indicate acknowledgement by initialing all boxes on the left side of the statements.

Part D: WAIVER OF PARTICIPATION

The employee must sign and date this section only if the employee waives participation in the Deferred Compensation Plan.



457 DEFERRED COMPENSATION PLAN ENROLLMENT/CHANGE FORM
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 3803 (Rev. 12-2014)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A PARTICIPANT INFORMATION	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID

PART B PROVIDER INFORMATION	
Name of Company (Required)	
Agent Name (Required)	Telephone Number

PART C CHECK ALL THAT APPLY	
<input type="checkbox"/> 1. New Application <input type="checkbox"/> 2. Increase Deduction <input type="checkbox"/> 3. Decrease Deduction <input type="checkbox"/> 4. Suspend Deduction (Includes going from full-time to part-time) <input type="checkbox"/> 5. Change Employer: From: _____ To: _____ <input type="checkbox"/> 6. Age 50 or older: Annual Catch-up <input type="checkbox"/> 7. Regular 3 Year Catch-up –457 Deferred Compensation Catch-up Worksheet Certification SFN 51501 MUST accompany this form <input type="checkbox"/> 8. Provider Change YOU MUST complete 2 Participant Agreement forms: 1. One for the new provider & √ 'New Application' 2. One to stop contributions to old provider & √ 'Suspend Deduction'	<input type="checkbox"/> 9. Change in Agent only (Complete Part A, B & F) <input type="checkbox"/> 10. USERRA Missed Contributions <input type="checkbox"/> 11. Lump sum Sick & Annual Leave (Form due at NDPERS by the 15 th of the month preceding payout date)

PART D CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION	
Must be completed if you checked 1, 2, 6, 7, 8, 10, or 11 in Part C	
A. Annual Gross Pay	\$ _____
B. Less Employer Retirement Contributions made under a IRC 414(h) arrangement (use most recent pay stub)	\$ _____
C. Includable Compensation (subtract B from A)	\$ _____
D. Maximum Annual Allowable Deduction:	
D 1. Lesser of 100% of Includable Compensation or annual maximum limit (see annual limits on back of form)	
Enter the lesser of D 1 but not less than the minimum annual deduction of \$300.00 (\$25.00) per month	\$ _____
E. Age 50 + catch-up (see annual limits on back of form)	\$ _____
F. Total D + E	\$ _____
G. Pay Period Deduction (F divided by number of pay periods in calendar year)	\$ _____

PART E SALARY REDUCTION AUTHORIZATION.	
Must be completed if you checked 1, 2, 6, 7, 8, 10, or 11 in Part C	
Authorization for deductions must be made in the month prior to the pay period in which the income is earned.	
I authorize my employer to reduce my salary in the amount of \$ _____ for the pay period beginning date (not date paid) _____.	
(The signature date in Part F must be in the month prior to the pay period date entered here.) (month, day, year)	
With regard to this agreement, the Participant acknowledges the following (read and initial each statement):	
_____	I understand that my salary will be reduced each pay period by the amount authorized above. The deduction can not be changed or stopped without an authorized participant agreement form returned to payroll from NDPERS.
_____	I understand the accumulated deferred salary is credited to my account and is not available to me or my beneficiary(ies) until I separate from service, unless, I should experience an unforeseeable emergency and a distribution is approved by the NDPERS Board. .
_____	I acknowledge that the Retirement Board makes no recommendation as to any provider and understand that the Retirement Board does not warrant or guarantee the investment performance of any provider.
_____	I understand that all compensation deferred under the Plan, and all earnings accruing thereof, shall be held for the exclusive benefit of myself or my Beneficiary, until such time as it is made available to me pursuant to the terms of the Plan.
_____	I understand that this agreement includes the beneficiary forms as executed with and maintained by my provider.

PART F PARTICIPANT AUTHORIZATION	
I verify that the foregoing statements are true and correct to the best of my knowledge and belief, and are subject to the laws and penalties governing any misrepresentations and fraud.	
_____	_____
Participant Authorization	Date
(This date must be in the month prior to the date entered in Part E)	



ANNUAL LIMITS

Annual Limit for 2015:	\$18,000
Age 50+ Limit for 2015:	\$24,000
Regular 3 Year Catchup:	\$36,000

PART A PARTICIPANT INFORMATION

For member identification, please provide all requested information.

PART B PROVIDER INFORMATION

If you check 'New Application in Part C, you must first select and contact one of the eligible providers for the plan. The provider representative you select will assist you in completing the required forms to open an account.

PART C CHECK ALL THAT APPLY

Check the applicable box(s).

PART D CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION

The minimum contribution is \$25.00 per month. The maximum regular annual contribution limit is the lesser of 100% of annual compensation or the annual maximum limit indicated above.

PART E SALARY REDUCTION AUTHORIZATION

The IRS regulations require you to make your deferral election in the month prior to the month the salary is earned.

PART F PARTICIPANT AUTHORIZATION

Sign where indicated. If you completed Part E, your signature must be dated in the month prior to the month entered in that section.