



# **Employee Selection Form**

## **Exclusive Provider Organization (EPO)**

Effective Date:    **0**  **1**

Employee Name: *Last* \_\_\_\_\_ *First* \_\_\_\_\_ *M.I.* \_\_\_\_\_

Employee Benefit Plan Number: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_

<input type="checkbox"/> <b>NEW HIRE</b>	<b>OPEN ENROLLMENT</b> <input type="checkbox"/> Transferring to EPO <input type="checkbox"/> Changing EPO network	<input type="checkbox"/> <b>CANCEL EPO COVERAGE</b> <small>(will automatically convert to Basic/PPO Plan effective July 1)</small>
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MeritCare Medical Group — Fargo

Altru Health Systems — Grand Forks

Innovis Health, LLC. — Fargo

Craven-Hagan/Mercy Medical — Williston

Medcenter One, Inc. — Bismarck

PrimeCare/St. Alexius Group — Bismarck

I understand that my Eligible Dependents and I must receive care within the provider network selected. Use of providers outside my affiliated network will result in a reduction of benefits, unless an Authorized Referral has been obtained.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If you have questions, call the NDPERS Service Unit:**

Toll-Free 1-800-223-1704

Fargo Local 282-1400

*Please return this form to your payroll office.*