



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.