



RETIREE HEALTH INSURANCE WITH MEDICARE APPLICATION
 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
 SFN 59562 (Rev. 3-2016)

59562

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									
Member Name (Last, First, Middle)						NDPERS Member ID			
Last Four Digits of Social Security Number						Date of Birth			
Spouse Name (Last, First, Middle)									
Address			City			State		Zip Code	
Daytime Telephone Number									
PART B LEVEL OF COVERAGE – CHOOSE ONE									
<input type="checkbox"/> I decline health insurance coverage at this time <input type="checkbox"/> Single Coverage (Self Only) <input type="checkbox"/> Family Coverage (Self and other eligible family members)									
PART C EFFECTIVE DATE & REASON									
Effective Date of Change (MM-DD-YYYY):									
<input type="checkbox"/> New Coverage (Select a Reason): <input type="checkbox"/> New Retiree <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Marriage (Date of Marriage ____/____/____) <input type="checkbox"/> Loss of Other Coverage (Attach a Certificate of Creditable Coverage or Employer Verification of Insurance Coverage SFN 53621) <input type="checkbox"/> Transfer from existing policy <input type="checkbox"/> Remove Dependent/Spouse <input type="checkbox"/> Add Dependent/Spouse: Is this an adult child? <input type="checkbox"/> No <input type="checkbox"/> Yes. <u>Please answer the following questions.</u> Is adult child eligible to enroll under their own or spouse's employer insurance plan? <input type="checkbox"/> No <input type="checkbox"/> Yes Is adult child disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes									
PART D DEPENDENT INFORMATION									
List all family members to be covered under the plan, <u>other than yourself</u> :									
a. Indicate <u>dependent's address</u> below name if address is different from yours. b. For <u>Relationship</u> to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild. c. For <u>Marital Status</u> , enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed d. 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. e. If you are adding a <u>grandchild</u> , a Grandchild Eligibility Verification SFN 60983 must be submitted also, along with a copy of the child's birth certificate.									
Are you or spouse or any of your eligible dependents currently covered by Medicare due to End Stage Renal Disease? <input type="checkbox"/> No <input type="checkbox"/> Yes									
Last Name	First Name	Middle Name	Date of Birth	Gender	Relationship	Marital Status	Medicare Part A*	Medicare Part B*	Effective Date
(Spouse)					Spouse		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	A: B:
(Dependent)							<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	A: B:
(Dependent)							<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	A: B:

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

NOTICE TO MEMBER

Please refer to the "Dakota Plan & Dakota Retiree Plan" information

*If you checked YES, in order to continue or be eligible for coverage you MUST submit a photocopy of the applicable Medicare ID card(s) for both Parts A & B and complete the NDPERS Medicare Prescription Drug Plan (PDP) Individual Enrollment Form. Therefore, any eligible Medicare member should not defer Part B of Medicare when he/she becomes eligible for it. The NDPERS Medicare Prescription Drug Plan (PDP) Individual Enrollment Form maybe obtained on our website at www.nd.gov/ndpers or by calling NDPERS at 328-3900 or 1-800-803-7377.

The NDPERS Medicare Prescription Drug Plan (PDP) Individual Enrollment Form SFN 58860 cannot be signed or submitted to NDPERS more than 90 days prior to the requested effective date of coverage.

If you are drawing a pension from a NDPERS defined benefit plan (NDPERS/NDHPRS), the Teacher's Fund for Retirement (TFFR), or the Job Service Retirement Plan, you can have your health insurance premium deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.

If you are drawing a pension from TIAA or the NDPERS Defined Contribution Plan or you are an ex-legislator, your health insurance premiums must be withheld from a bank account.

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written request must be submitted. The request must provide the contract holder's name, last four digits of social security number, NDPERS Member Id and effective date. A NDPERS Disenrollment form is also required for any individual on Medicare. NDPERS must receive a cancellation request by the end of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

PART F PAYMENT METHOD

RETIREMENT GROUP

- NDPERS/NDHPRS TFFR Job Service
 TIAA NDPERS Defined Contribution
 Ex-Legislator Alternate Retirement System

PAYMENT OPTION – MUST SELECT ONE

- Deduct from pension check (Option only available for NDPERS/NDHPRS, TFFR, Job Service)
 Withhold from bank account (Complete SFN 50134)

PART G MEMBER AUTHORIZATION

I authorize the Social Security Administration to furnish Sanford Health Plan with medical or other information acquired under the Title XVIII Program (MEDICARE) during the periods my contracts are in force. I authorize Sanford Health Plan, or its agent to receive medical information from physicians, hospitals, and other health care providers in order to assure appropriateness of claims payment.

I read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any Benefit Plans insured based on this application.

Signature of Applicant

Date Signed