



ESTIMATED BENEFIT PAYMENT REQUEST
 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
 SFN 59058 (Rev. 03-2015)

59058

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

PART A PARTICIPANT IDENTIFICATION	
Name (Last, First Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
PART B BENEFIT ESTIMATE PARAMETERS	
Retirement Effective Date:	
Benefit Option:	
<input type="checkbox"/> Single Life <input type="checkbox"/> Normal Retirement (Judge & Highway Patrol) <input type="checkbox"/> 50% Joint Survivor/Life <input type="checkbox"/> 100% Joint Survivor/Life <input type="checkbox"/> 10 Year Term Certain/Life <input type="checkbox"/> 20 Year Term Certain/Life	
Health Insurance: <input type="checkbox"/> Single <input type="checkbox"/> Family of 2 <input type="checkbox"/> Family of 3 or more	Medicare: <input type="checkbox"/> No <input type="checkbox"/> Yes, # of policies _____
Life Insurance:	
<input type="checkbox"/> Basic Life (\$1,300) <input type="checkbox"/> Supplemental Life: \$ _____ .00 <input type="checkbox"/> Dependent Life: \$ _____ .00 <input type="checkbox"/> Spouse Supplemental Life: \$ _____ .00	
Dental: <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree + Spouse <input type="checkbox"/> Retiree + Child(ren) <input type="checkbox"/> Retiree + Family	
Vision: <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree + Spouse <input type="checkbox"/> Retiree + Child(ren) <input type="checkbox"/> Retiree + Family	
Long Term Care Premium: \$ _____	
Federal Income Tax: Marital status for Part C is determined by the Federal law definition of marriage.	
1. <input type="checkbox"/> I elect NOT to have federal income tax withheld.	
2a. <input type="checkbox"/> I want federal income tax withheld from each periodic pension payment which is figured by using the number of allowances and marital status shown below: (You may also designate an additional amount on line 2b.)	
Step 1: Check marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withholding at the higher Single rate Step 2: Enter number of allowances → _____	
2b. <input type="checkbox"/> I want the following <u>additional</u> amount withheld. \$ _____	
3. <input type="checkbox"/> I want the following flat amount withheld \$ _____	
North Dakota State Income Tax: Marital status for Part D is determined by the definition of marriage under North Dakota law.	
1. <input type="checkbox"/> I elect NOT to have ND State income tax withheld.	
2a. <input type="checkbox"/> I want ND State income tax withheld from each periodic pension payment which is figured by using the number of allowances and marital status shown below: (You may also designate an additional amount on line 2b.)	
Step 1: Check marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withholding at the higher Single rate Step 2: Enter number of allowances → _____	
2b. <input type="checkbox"/> I want the following <u>additional</u> amount withheld. \$ _____	
3. <input type="checkbox"/> I want the following flat amount withheld \$ _____	

PART A PARTICIPANT INFORMATION

For member identification, please provide all requested information.

PART B BENEFIT ESTIMATE PARAMETERS

Benefit Option:

Select the option you have elected to draw your retirement benefits under.

Health Insurance:

If you elect to continue or apply for NDPERS group health insurance coverage, select level of coverage. If you or any member on the policy is or will be eligible for Medicare, please indicate the number of people.

Life Insurance:

If you elect to continue your NDPERS life insurance coverage, select the level of coverage.

If you are under age 65, you may either maintain the same level(s) of coverage you had as an active employee or elect to decrease or discontinue your level(s) of coverage. You cannot increase any coverage levels, apply for coverage you are not participating in at the time of retirement, nor are you eligible for the annual enrollment. If you are age 65 or older, you may only maintain the basic level of coverage.

Dental Insurance:

If you elect to continue or apply for NDPERS group dental insurance coverage, select level of coverage.

Vision Insurance:

If you elect to continue or apply for NDPERS group vision insurance coverage, select level of coverage.

Long Term Care Premium:

If you elect to continue or apply for NDPERS group long term care insurance, indicate the total premium you will be paying.

Federal and North Dakota State Income Tax Sections:

Your benefits from NDPERS are subject to federal and state income tax withholding. If you choose not to have tax withheld or do not have enough tax withheld, you may have to make additional tax payments to the Internal Revenue Service (IRS). You may be subject to penalties if your payments of estimated tax and withholding are not sufficient.



APPLICATION FOR DEFERRED RETIREMENT BENEFITS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 59044 (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 PARTICIPANT 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 APPLICATION TO DEFER RETIREMENT BENEFITS	
NDPERS Deferred Retirement Effective: <input type="checkbox"/> Date to be later determined <input type="checkbox"/> Normal Retirement Date <input type="checkbox"/> Other _____ / 1 / _____	
PART C SICK LEAVE CONVERSION (DEFINED BENEFIT PLAN ONLY)	
Do you wish to purchase all or part of your unused sick leave into retirement service credit? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, complete and return the Conversion Of Unused Sick Leave Application – Defined Benefit SFN 58358.	
PART D AUTHORIZATION	
I elect to defer my retirement benefits and health credit as indicated in PART B. I understand that I must submit an application to commence retirement benefits to NDPERS at least 30 days before distribution of my first retirement check.	
_____	_____
Member's Signature	Date

Please refer to the “Group Retirement Plan” sheet.

Part A Participant Identification

For member identification, please provide all requested information.

Part B Application to Defer Retirement Benefits

You may defer your retirement benefits to a later. This is a date you tentatively wish to commence benefits. You have the option to delay your benefits until you are required by law to receive minimum required distributions. Whether vested or not, you can leave your Member Account Balance intact with NDPERS. Interest continues to compound on your Member Account Balance until you begin receiving a pension.

Part C: Sick Leave Conversion

This section is to be completed ONLY if you participate in the Defined Benefit Plan. Defined Contribution Plan members are not eligible to purchase unused sick leave.

Part D: Authorization

YOU MUST SIGN AND DATE PART D TO VALIDATE THIS FORM.



CONVERSION OF UNUSED SICK LEAVE APPLICATION- DEFINED BENEFIT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58358 (Rev. 01-2014)

**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 PARTICIPANT IDENTIFICATION

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

PART B NOTICE TO MEMBER

I understand that I have the opportunity to convert any unused sick leave that I accrued with my employer as of my termination date. Payments can be made to NDPERS as an after-tax payment through a personal check or as a pre-tax payment through a direct rollover or trustee-to-trustee transfer of an eligible fund towards the retirement portion of the sick leave conversion. I have had the opportunity to speak to a financial planner and NDPERS regarding my election and to ask any questions I may have concerning this election. I understand that this election must be made prior to disbursement of any retirement benefits. My election regarding payment is indicated in Part D or Part E.

PART C HOURS OF UNUSED SICK LEAVE

Projected number of hours of unused sick leave [formula = hours ÷ 173.3 = months] (rounded up): _____
 Number of months you wish to convert: _____

PART D APPLICATION FOR AFTER TAX PAYMENT THROUGH PERSONAL CHECK

I elect to convert my unused sick leave and to pay for it through an after-tax payment. I understand that NDPERS will provide the cost for the sick leave conversion following my termination of employment. I will have until the 15th of the month following my month of termination to pay for the conversion. I understand that I must submit payment by the 15th of the month prior to my first retirement check date as not to delay the payment of this first benefit.

PART E APPLICATION FOR PRE-TAX PAYMENT THROUGH DIRECT ROLLOVER/TRANSFER

I elect to convert my unused sick leave and to pay for the retirement portion of the conversion through a pre-tax payment by direct rollover or transfer from an eligible fund source. I understand that by electing this option, NDPERS will determine the estimated cost 60 days prior to my termination date and will provide this information to me. The direct rollover or transfer must be received by NDPERS by the 15th of the month following my month of termination. If I elect to use a direct rollover or transfer, I will submit payment for the retiree health insurance credit portion by personal check. The final cost will be calculated upon my termination. If there is a difference between the sick leave balance or conversion payment amount and the amount that I paid, then only the amount of sick leave available as of the date of termination will be added to my member record. The funds for the over-payment can not be returned due to the pre-tax nature of the funds. My member account balance will be credited with the full amount of funds received from the rollover or transfer. If an underpayment occurred, then I will pay the remaining amount by the 15th of the month following my month of termination date. I authorize my employer to document my expected salaries for the 60 days prior to my termination of employment under section F.

PART F EMPLOYER SALARY VERIFICATION – COMPLETE IF PART E ELECTED BY MEMBER

Indicate Month(s) and Projected Salary		
Month	Year	Indicate Projected Gross Salary
		\$
		\$
		\$

The salaries above are the projected gross salaries that this individual is expected to earn within 60 days of the termination date as specified on the Notice of Status or Employment Change SFN 53611. To the best of my knowledge and belief, the information that I have provided on this form is correct.

_____	_____
Signature of Authorized Agent	Date

PART G MEMBER ELECTION

To the best of my knowledge and belief, the information that I have provided on this form is correct.

_____	_____
Signature of Member	Date



INSTRUCTIONS

PART A PARTICIPANT IDENTIFICATION

Enter your name, NDPERS member id, last four digits of social security number, and date of birth.

PART B NOTICE OF MEMBER

Read this section carefully! This section contains important information that you need to know before making an election.

PART C HOURS OF UNUSED SICK LEAVE

Enter number of months you have eligible and number of months you wish to convert.

PART D APPLICATION FOR AFTER TAX PAYMENT THROUGH PERSONAL CHECK

Complete this section to authorize payment for your unused sick leave through a personal check.

PART E APPLICATION FOR PRE-TAX PAYMENT THROUGH DIRECT ROLLOVER/TRANSFER

Complete this section to authorize a payment for your unused sick leave through a direct rollover/transfer from an eligible fund source.

PART F MEMBER ELECTION

If Part E is elected by the member, the employer must provide written certification of the projected gross salaries to be reported to NDPERS during the final 60 days of employment.

PART G MEMBER ELECTION

The member must sign and date this section to verify their election.



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.

**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)			<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>

PART A APPLICANT INFORMATION

For applicant identification, please provide all requested information.

PART B QUALIFYING COBRA EVENT

- Check the box that describes the event that qualifies you for continuation coverage.
- Indicate the group insurance plan(s) you are electing for continuation coverage.
- Check the level of coverage. If you are not applying for the coverage, check the waive box.
- List all covered individuals. You may elect continuation coverage for only those family members that were covered on the plan at the time of the qualifying event.

PART C PAYMENT METHOD

If you check withhold from bank account, you must complete an Authorization for Automatic Premium Deduction SFN 50134. If a payment option is not elected, you will be billed for the premium due and will have 45 days from the date of this election to make your initial premium payment. Your continuation coverage will not be effective until the initial premium payment is received. NDPERS bills the 20th of each month for the following month's coverage. Your payment is due the 1st of the month. **Failure to remit your premium by the due date will result in loss of insurance coverage.**

PART D APPLICANT AUTHORIZATION

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

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS

LIFE CONVERSION INFORMATION REQUEST

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
PO Box 20, Minneapolis, MN 55440



Instructions

Employer/Plan Administrator: This form should be completed and furnished to every person who has the conversion right.

Employee/Member/Owner (person requesting information): Complete the employee/member/spouse/children section and mail to the insurer at the address shown below within 31 days (see the certificate for applicable time period) of the date of termination of group coverage.

TO BE COMPLETED BY EMPLOYER/PLAN ADMINISTRATOR

Group Policyholder/Plan Name _____ Policy Plan Number _____

Account Number _____ Group Situs _____

Employee/Member Name (Last, First, MI) _____

Birth Date _____ SSN _____

Is employee/member disabled? Yes No If "Yes," give disability date. _____

Does policy have waiver provision? Yes No Was ownership assigned? Yes No

Initial Insurance Effective Date (with ReliaStar) _____ Employment Termination Date (if applicable) _____

Insurance Termination Date (DO NOT include grace period.) _____

COVERAGE TERMINATING

	Basic Amount	Supplemental/Voluntary Amount	Other	Total Amount Eligible for Conversion
<input type="checkbox"/> Employee/Member	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Spouse	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Children (each)	\$ _____	\$ _____	\$ _____	\$ _____

Reason for termination: Termination of employment Termination of group policy Reduction of coverage Retirement

Loss of Spouse/Child Status Death of Employee (list Spouse name) _____

Other (specify) _____

This form will be: Handed Mailed to Employee/Member/Owner (Date delivered or mailed.) _____

➔ Employer/Plan Administrator Signature _____ Date _____

Title _____ Company Phone (_____) _____

TO BE COMPLETED BY EMPLOYEE/MEMBER/OWNER (Do not mail this form to insurer unless top portion is completed and signed by Employer/Plan Administrator.)

Requestor Name (Last, First, MI) _____

Address _____ City _____ State _____ ZIP _____

Relationship to Employee/Member _____ Home Phone (_____) _____

➔ Signature _____ Date _____

The Group Term Life Insurance coverages are terminating as indicated above. You may be eligible to convert existing coverage(s) to an individual life policy by mailing this form within 31 days (see the certificate for applicable time period) of such termination.

Please read the Conversion section/provision in the group certificate to determine eligibility. Complete this form and mail without delay. ReliaStar will send you a description of the conversion plan, premium rates and an application form.

Important Notice: This is not an application for conversion of group life coverage. Receipt of this form does not guarantee your eligibility to convert group coverage.

IF YOU DO NOT RECEIVE INFORMATION WITHIN 21 DAYS AFTER THE DATE YOU MAILED THIS FORM, PLEASE CALL (800) 955-7736.

Please mail to: Voya Employee Benefits, Group Conversions, Route 2-N, PO Box 20, Minneapolis, Minnesota 55440-0020

Do not enclose payment with this form. Send the entire form, when completed, to the above address.

PREMIUM RATES FOR WHOLE LIFE CONVERSION POLICIES (Rates are based on annual premium per \$1,000 of insurance.)

Age	Rate	Age	Rate	Age	Rate	Age	Rate
0	7.75	25	12.30	50	38.99	75	149.65
1	7.85	26	13.03	51	41.10	76	156.19
2	7.94	27	13.90	52	43.40	77	163.12
3	8.05	28	14.55	53	45.99	78	170.47
4	8.15	29	15.22	54	48.12	79	178.35
5	8.28	30	15.93	55	50.51	80	186.88
6	8.41	31	16.64	56	53.45	81	196.19
7	8.56	32	17.40	57	56.70	82	206.38
8	8.70	33	18.20	58	59.68	83	217.63
9	8.86	34	18.49	59	63.23	84	230.06
10	9.05	35	19.09	60	67.41	85	243.87
11	9.24	36	20.22	61	72.72	86	259.20
12	9.41	37	21.68	62	77.30	87	276.26
13	9.55	38	22.67	63	82.01	88	295.24
14	9.69	39	23.76	64	86.03	89	316.37
15	9.85	40	24.84	65	90.88	90	339.83
16	10.00	41	25.06	66	96.83	91	365.89
17	10.16	42	26.14	67	103.40	92	394.78
18	10.36	43	27.30	68	108.97	93	426.76
19	10.58	44	28.40	69	114.59	94	462.09
20	10.82	45	29.79	70	120.27	95	501.05
21	10.92	46	31.48	71	125.60	96	543.91
22	11.32	47	33.38	72	131.39	97	591.02
23	11.77	48	35.17	73	137.30	98	642.62
24	11.97	49	37.05	74	143.36	99	699.09

Issued by ReliaStar Life Insurance Company, policy form RL-WL2-POL-07 (may vary by state).

Example of Calculating Premium

Currently, you have \$25,000 of basic coverage under your group policy. Your current age is 35. When that term life insurance stops, you want to convert the entire amount. You want to be billed semi-annually.

Use the following steps to calculate the premium:

1. Determine the amount of coverage you wish to convert. **\$25,000**
2. Calculate the number of thousands you wish to convert by dividing the amount from step 1 by 1,000. **\$25,000/1,000 = 25**
3. Find the rate corresponding to your age at the time of conversion. **\$19.09**
4. Multiply the number of thousands from step 2 by the rate found in step 3. **25 * 19.09 = \$477.25**
5. Find a policy fee corresponding to the amount of coverage you elected in step 1. **\$12.00**
6. Add the policy fee to the amount in step 4. **\$477.25 + 12.00 = \$489.25**
7. Multiply the amount in previous step by 0.265 for Quarterly billings, 0.515 for Semi-Annual billings, and 1 for Annual billings: **\$489.25 * 0.515 = \$251.96**

\$251.96 is your semi-annual premium amount, which you need to submit with the application.

Please note: Calculate premium separately for each proposed insured person, but submit one check.

ANNUAL POLICY FEES FOR WHOLE LIFE INSURANCE	
Converted Face Amount	Policy Fee Amount
\$1,000 – \$500,000	\$12.00
\$500,001 - \$1,000,000	\$24.00
\$1,000,001 - \$1,500,000	\$36.00
\$1,500,001 - \$2,000,000	\$48.00



Conversion of your Group Term Life Insurance Coverage

What is conversion?

If you leave your job or your hours are reduced, you and your family may lose eligibility for group term life insurance coverage through your employer or association. Conversion allows you to convert life insurance coverage to an individual whole life policy when you or your family members are no longer eligible for group coverage.

Why should I keep my life insurance coverage?

How would your loved ones be affected if you passed away and they were left without your financial resources? Would they be able to pay their everyday expenses or would they need to make sacrifices? Below are a few examples of how life insurance benefits could be used (coverage amounts may vary):

- Pay off any remaining medical bills, funeral costs and debts
- Provide ongoing financial support to your family
- Keep your family in your home by paying off the mortgage
- Fund your children's education

What kind of conversion insurance plan is this?

It is referred to as an individual "non-participating" whole life insurance policy.¹ The individual whole life policy has a guaranteed cash value, which is a cash account that gradually builds as you pay premiums. You may be able to use this money at a later time for emergencies or temporary needs.

Why should I convert my coverage?

- When you convert your coverage, you will lock in your premium payments when the new policy is issued – you will pay the same rate for life with no increases in premium due to age or health²
- The whole life policy is payable to age 121
- You do not need to provide proof of good health when converting your coverage

Will my coverage amounts stay the same?

When no longer eligible for coverage under the group policy you may convert coverage for yourself, your spouse and your children. You may convert any amount up to the amount you previously held. Any additional benefits such as Waiver of Premium, Accidental Death and Dismemberment or Accelerated Death Benefit will not be converted.

How do I convert my coverage?

Simply send in your Life Conversion Information Request Form to request an application within 31 days following the date any part of your group life insurance ends.

What is the time period for conversion?

You must return the conversion application and pay the first premium within 21 days of the date the conversion packet was mailed to you.



Request an application today!

The offer to convert your coverage will expire in 31 days



Return your Life Conversion Information Request Form to request an application and take advantage of a fixed whole life insurance rate for life! Please refer to your Life Conversion Information Request Form for a copy of conversion rates and fees.

¹Minnesota employees may have the option of electing term life continuation in place of this conversion; contact your employer for more information.

²Your cost includes an annual policy fee based on the amount of coverage you choose to convert.

Insurance products are underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Home and Administrative Office: 20 Washington Avenue South, Minneapolis, MN 55401

©2015 Voya Services Company. All rights reserved. LG12306

151671 02/15/2015

IMPORTANT NOTICE - This form is to be used only for North Dakota Public Employees Retirement System Group Insurance Deductions. **THIS FORM ONLY AUTHORIZES DEDUCTIONS FROM YOUR ACCOUNT.**

INSTRUCTIONS AND CONDITIONS

If you wish to have your monthly insurance premiums deducted from your savings or checking account, you must complete this form to authorize this action. The North Dakota Public Employees Retirement System will deduct these premiums to the point you authorize. The financial institution may be any bank, savings bank, savings and loan association or similar institution, or Federal or State chartered credit union.

PART A PARTICIPANT IDENTIFICATION

For member identification, please provide all requested information.

PART B MEMBER AUTHORIZATION

Check the type of insurance premium(s) you are requesting to be withheld from your bank account. Sign and date the form.

PART C FINANCIAL INSTITUTION

Attach a voided check; if a voided check is not attached, your authorization form premium deduction will be returned.

CANCELLATION INSTRUCTIONS

When entered in your record with the North Dakota Public Employees Retirement System, this authorization will remain in effect until canceled by written notice by you to the North Dakota Public Employees Retirement System, or in the event of your death. The financial organization should also be notified if you cancel this agreement.

The financial organization may cancel their agreement by providing you a written notice 30 days in advance of the cancellation date. You must advise the North Dakota Public Employees Retirement System if this authorization is canceled. The financial organization cannot cancel this authorization by advice to the North Dakota Public Employees Retirement System.

The form is due back in our office by the 15th of the month prior to the month you want to begin your premium deduction



ELECTION TO CONTINUE YOUR LONG TERM CARE INSURANCE COVERAGE

Mail to: Unum Life Insurance Company of America
LTC Customer Services
2211 Congress Street
Portland, Maine 04122

Policy Number: _____

TO BE COMPLETED BY THE EMPLOYER

Company Name _____ Plan Number _____

Company Data:

Street _____ City _____ State/Zip _____

Company Address:

Last Name _____ First Name _____ Middle Initial _____

Employee Name:

Date of Birth _____ Social Security Number _____ Male

Employee Data:

Female

Person terminating group coverage:

Name(s) _____ Employee

Employee's Spouse or Domestic Partner (if applicable)

Reason person is terminating group coverage: Termination of Employment Death of Spouse or Domestic Partner

Divorce Other

Date group coverage terminates:

Month _____ Day _____ Year _____

Current monthly premium payment:

Employee \$ _____ /month Spouse \$ _____ /month

Signature of Employer: _____

Date: _____

TO BE COMPLETED BY THE EMPLOYEE

If you are an insured employee, you may be eligible to continue your long term care insurance coverage after your group coverage terminates. If you wish to continue your coverage, please complete this form and return it to the insurer at the address listed above. This form must be completed and returned within the time period specified in your certificate. **You will be responsible for the entire cost of your coverage.** Unum will mail bills to you at the address you provide below.

Street _____ City _____ State/Zip _____ Telephone _____

Mailing Address:

Monthly _____ Quarterly (Paper) _____ Semi-Annually (Paper) _____ Annually (Paper) _____

Payment Options: Automatic payment via checking account (3x monthly rate) (6x monthly rate) (12x monthly rate)

Signature of Employee: _____

Date: _____

TO BE COMPLETED BY THE EMPLOYEE'S SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

If you are the insured spouse or domestic partner or former spouse or domestic partner of the above employee, you may be eligible to continue your long term care insurance coverage after your group coverage terminates. If you wish to continue your coverage, please complete this form and return it to the insurer at the address listed above. This form must be completed and returned within the time period specified in your certificate. **You will be responsible for the entire cost of your coverage.** Unum will mail bills to you at the address you provide below.

Last Name _____ First Name _____ Middle Initial _____

Name:

Street _____ City _____ State/Zip _____ Telephone _____

Mailing Address:

Date of Birth _____ Social Security Number _____ Male

Data: Female

Monthly _____ Quarterly (Paper) _____ Semi-Annually (Paper) _____ Annually (Paper) _____

Payment Options: Automatic payment via checking account (3x monthly rate) (6x monthly rate) (12x monthly rate)

Signature of Employee's Spouse/Domestic Partner: _____

Date: _____

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

Information About Continuing Your Long Term Care Insurance Coverage

Should The Certificate Of Insurance Be Kept?

If you elect to continue your long term care coverage, you will not receive a new Certificate of Insurance. You should keep the Certificate of Coverage that was issued to you under the group plan.

Can Coverage Be Changed?

You may apply at any time to increase coverage by filling out a new application, which includes evidence of insurability. Call Unum at (800) 227-4165 for assistance.

Where Should Premium Payments Be Sent?

You must remit all premium payments directly to Unum. The address is:
Unum Life Insurance Company of America
P.O. Box 406933
Atlanta, Georgia 30384-6933

Your Certificate of Coverage sets forth in detail the rights and obligations of both you and the insurer. Please refer to your Certificate for more information including the number of days in your grace period, how long Unum will continue to pay for long term care benefits and when your coverage will terminate.

**PROTECTION AGAINST UNINTENTIONAL LAPSE
ADDITIONAL DESIGNATION
GROUP LONG TERM CARE INSURANCE**

Your Name: _____

Your Social Security Number: _____

Policyholder's Name: _____

Policy Number: _____

You, the insured, will receive notice if any coverage for which you are required to pay the cost is about to terminate because you have not paid the required premiums.

You are required to provide your insurer with a written designation of at least one person, in addition to you, who is to receive the notice of cancellation of your coverage for nonpayment of premium OR sign a waiver electing not to designate a person. You have the right to change these designations. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to you. The designated person or persons will not receive the notice until 30 days after the premium is due and unpaid.

My designations are as follows:

Name: _____

Address: Street/P.O. Box: _____ City, State, Zip Code: _____

Name: _____

Address: Street/P.O. Box: _____ City, State, Zip Code: _____

Insured's Signature: _____ Date: _____

**WAIVER ELECTING NOT TO NAME AN ADDITIONAL DESIGNATION
FOR PROTECTION AGAINST UNINTENTIONAL LAPSE**

I understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. **I elect NOT to designate any person to receive such notice.**

Insured's Signature: _____ Date: _____

Please return this form to:
Group Long Term Care
Unum Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122

New Jersey and New York Residents – Age 62 and older: Per New Jersey insurance code C.17:29C-1.2 and §3111 of the New York Insurance Laws, this form shall be delivered to Unum by certified mail, return receipt requested along with the completed Designee Acceptance form (on the back page of this form). Your Designee(s) must accept in writing that they are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from us.

Please retain a copy of this form for your records

**DESIGNEE ACCEPTANCE
LONG TERM CARE INSURANCE**

This form needs to be completed by the Designee, if the named Insured is age 62 or over and a resident of New Jersey or New York.

Insurance Applicant: Please complete this section prior to sending this form to your Designee for signature.

Insured's Name: _____

Policy Number: _____

Prior to issuing a long term care policy; the Insured is required to provide the insurer with a written designation of at least one person, who is to receive the notice of cancellation of this policy for nonpayment of premium, in addition to the insured OR sign a waiver electing not to designate a person. You have been listed as one of the designees. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to the insured.

You must accept in writing that you are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from the insurer. Should you desire to terminate the status as a third party designee, you shall provide written notice to both the insurer and the insured.

Designee's Signature: _____

Print Name: _____

Date: _____

Please retain a copy of this form for your records



CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)
 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
 SFN 53512 (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 PARTICIPANT/QUALIFIED BENEFICIARY INFORMATION

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

PART B CONTINUATION OF COVERAGE ELECTION / WAIVER

If you elect Medical Spending Continuation coverage, it will be in effect to the end of the current plan year, or December 31.

Do you wish to continue your current participation in the NDPERS Flexcomp Plan Medical Spending Account? Yes No

- I wish to pre-pay the premium through the end of the plan year with pre-tax dollars deducted from my final pay checks.
- I will pay the premium plus a 2% administration fee with after-tax dollars through the remainder of the plan year.

PART C AUTHORIZATION OF APPLICANT

I have read the information in its entirety, **including the back page**, and agree to abide by the terms of the Plan Document. I certify, under penalties of perjury, that the information submitted on this form is true, correct and complete.

 Applicant's Signature

 Date of Signature



Entitlement to COBRA Coverage

Under provisions of the Internal Revenue Service (IRS) COBRA regulations, you have the opportunity to extend your participation in the Medical Spending Account to the end of the current plan year.

The employer has the responsibility to notify NDPERS of a participant's death, termination, or reduction in hours of employment.

Qualified Beneficiaries Your spouse or dependent(s) may elect to continue coverage in a medical spending account under the following circumstances:

1. Participant's death.
2. Divorce or legal separation.
3. A dependent child ceases to be a "dependent child" under the group health plan.

If you elect COBRA continuation, your premium payment will be based on the annual election amount in existence at the time of the qualifying event.

Under the law, it is the responsibility of the person seeking continuation coverage to inform NDPERS of a divorce, legal separation or a child losing dependent status within 60 days of the date of the event. If you are interested in COBRA continuation coverage, contact NDPERS for more information.

Length of COBRA Coverage

You, your spouse or dependent(s), are eligible to receive continuation coverage until the end of the plan year, or December 31, in which the qualifying event occurred. If you have paid your premium through the end of the year on December 31 and have a balance in your account, you have the option to have eligible expenses incurred during the "grace period", from January 1 through March 15 of the new plan year, reimbursed from that remaining balance. You will have until April 30 to submit claims. Any amount remaining in your medical spending reimbursement account after the April 30 claims filing deadline is forfeited.

COBRA Coverage Premiums

Employees who elect COBRA continuation coverage are permitted to pre-tax the COBRA premium and pre-pay the premium through the end of the current plan year from their final paychecks.

To pay the premium with after-tax dollars throughout the plan year, submit the premium amount plus a two percent (2%) administrative fee by the first of each month. If you fail to pay the premium on time, your coverage will terminate on the last day of the month for which a contribution was received.

Continuation coverage under COBRA is provided subject to your eligibility. NDPERS reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

You will have 60 days from the date of this notice to inform NDPERS that you want continuation coverage.

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS OF THE DATE OF THIS NOTICE YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE