



ESTIMATED BENEFIT PAYMENT REQUEST
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 59058 (Rev. 01-2010)

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

Benefit Option:

Single Life Normal Retirement (Judge & Highway Patrol)

50% Joint Survivor/Life 100% Joint Survivor/Life

10 Year Term Certain/Life 20 Year Term Certain/Life

Social Security Level Income: Indicate age when benefits will begin: _____ SSA Benefit: \$ _____

Health Insurance: Single Family of 2 Family of 3 or more **Medicare:** No Yes, # of policies _____

Life Insurance:

Basic Life (\$1,300) Supplemental Life: \$ _____ .00 Dependent Life: \$ _____ .00

Spouse Supplemental Life: \$ _____ .00

Dental: Retiree Only Retiree + Spouse Retiree + Child(ren) Retiree + Family

Vision: Retiree Only Retiree + Spouse Retiree + Child(ren) Retiree + Family

Long Term Care Premium: \$ _____

Federal Income Tax:

1. I elect NOT to have federal income tax withheld.

2a. 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: Single Married Married, but withholding at the higher Single rate

Step 2: Enter number of allowances → _____

2b. I want the following additional amount withheld. \$ _____

3. I want the following **flat** amount withheld \$ _____

North Dakota State Income Tax:

1. I elect NOT to have ND State income tax withheld.

2a. 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: Single Married Married, but withholding at the higher Single rate

Step 2: Enter number of allowances → _____

2b. I want the following additional amount withheld. \$ _____

3. 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. 01-2010)

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
Department/Agency	NDPERS Organization ID
PART B APPLICATION TO DEFER RETIREMENT BENEFITS	
NDPERS Deferred Retirement Effective (Month / 1 / Year) _____ / 1 / _____	
DEFINED BENEFIT PLAN	DEFINED CONTRIBUTION PLAN
SECTION 1 RETIREMENT PAYMENT OPTIONS (Check One)	
<input type="checkbox"/> Monthly Benefit Payment: (Check One) <input type="checkbox"/> Single Life / Normal Retirement <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 <input type="checkbox"/> Social Security Level Income:(Check One) <input type="checkbox"/> Age 62 <input type="checkbox"/> ____ other age <input type="checkbox"/> Social Security Normal Retirement Age	<input type="checkbox"/> Periodic Payment
SECTION 2 RETIREE HEALTH CREDIT OPTIONS (Check One)	
<input type="checkbox"/> I elect the standard retiree health credit option specific to the retirement option selected in section 2. <input type="checkbox"/> If married and selected either the single life, 20 or 10 year term certain/life, or social security level income; I elect the following alternate actuarially reduced retiree health credit option: (Check One): <input type="checkbox"/> 50% Joint Survivor Life <input type="checkbox"/> 100% Joint Survivor Life	<input type="checkbox"/> I elect the standard retiree health credit option <input type="checkbox"/> If married, I elect the following alternate actuarially reduced retiree health credit option: (Check One): <input type="checkbox"/> 50% Joint Survivor Life <input type="checkbox"/> 100% Joint Survivor Life
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 <u>Yes</u>, 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

Enter the month and year you want your retirement benefits to begin. 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.

If you participate in the Defined Benefit Plan, complete the left side of Part B. If you participate in the Defined Contribution Plan, complete the right side of Part B.

- Section 1: Check your retirement payment option. You will reaffirm your election once you make application to commence drawing a pension.
- Section 2: Check your retiree health credit option. You will reaffirm your election once you make application to commence drawing 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. 03-2010)

**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		
<input type="checkbox"/> 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 15 th of the month following my month of termination to pay for the conversion. I understand that I must submit payment by the 15 th 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		
<input type="checkbox"/> 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 15 th 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 15 th 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. 01-2011)

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					
<p>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.</p>					
_____			_____		
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					
<p>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).</p>					
<p>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.</p>					
<p>I consent to the above retirement beneficiary (ies) designated by the above named NDPERS member.</p>					
_____			_____		
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:** 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 Form

ReliaStar Life Insurance Company
 PO Box 20, Minneapolis, Minnesota 55440
 A member of the ING family of companies

Instructions

Employer/Group

This form should be completed and furnished to every person who has the conversion right.

Employee/spouse/dependent (person requesting information)

Complete the employee/spouse/dependent section and mail to the insurer at the address shown below within 31 days (see your certificate for applicable time period) of the date of termination of group coverage.

To be completed by Employer

Group policyholder or plan name		Policy plan number	Account number	Group Situs
Employee's name – Last		First	M.I.	Date of birth
Social Security number				
Is employee disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", give date of disability	Does policy have waiver provision? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was ownership assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Initial insurance effective date (with ReliaStar)		Employment termination date	Insurance termination date (DO NOT include grace period)	

Coverage terminating

Reason for termination

<input type="checkbox"/> Employee Basic Amount \$ _____ Supplemental/Voluntary amount \$ _____ Other \$ _____ Total amount eligible for conversion \$ _____	<input type="checkbox"/> Termination of employment <input type="checkbox"/> Termination of group policy <input type="checkbox"/> Reduction of coverage <input type="checkbox"/> Retirement <input type="checkbox"/> Loss of Dependent Status <input type="checkbox"/> Disabled <input type="checkbox"/> Death of Employee Spouse name _____ <input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Dependent spouse Basic Amount \$ _____ Supplemental/Voluntary amount \$ _____ Other \$ _____ Total amount eligible for conversion \$ _____	
<input type="checkbox"/> Dependent children (each) Basic Amount \$ _____ Supplemental/Voluntary amount \$ _____ Other \$ _____ Total amount eligible for conversion \$ _____	

This form will be handed mailed to employee/spouse/dependent _____ (date)

Signature (employer)	Title	Company phone number
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To be completed by Employee/spouse/dependent (do not mail this form to insurer unless top portion is completed and signed by Employer/Administrator).

Requestor's name – Last		First	M.I.	Relationship to employee	
Home address – Street		City	State	ZIP	
Signature		Date	Home Phone number		

Your Group Insurance Benefits are terminating as indicated above. You may be eligible to convert to an individual life policy by mailing this form within 31 days (see your certificate for applicable time period) of such termination. Please read the Conversion Right in your group certificate to determine your 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 your group life plan coverage. Receipt of this form does not guarantee your eligibility to convert your 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:

**ING Employee Benefits
 Group Conversions, Route 8525
 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	6.20	25	10.93	50	35.05	75	133.61
1	6.28	26	11.44	51	36.90	76	139.46
2	6.34	27	11.98	52	38.97	77	145.64
3	6.43	28	12.54	53	41.30	78	152.20
4	6.52	29	13.12	54	43.60	79	159.24
5	6.62	30	13.73	55	45.92	80	166.86
6	6.72	31	14.37	56	48.41	81	175.17
7	6.84	32	15.03	57	50.95	82	184.27
8	6.96	33	15.73	58	53.64	83	194.31
9	7.09	34	16.46	59	56.84	84	205.41
10	7.23	35	17.20	60	60.60	85	217.74
11	7.38	36	17.96	61	64.59	86	231.43
12	7.53	37	18.77	62	68.67	87	246.66
13	7.69	38	19.64	63	72.88	88	263.61
14	7.84	39	20.58	64	77.48	89	282.47
15	8.00	40	21.53	65	82.24	90	303.42
16	8.27	41	22.50	66	87.08	91	326.69
17	8.60	42	23.48	67	91.98	92	352.48
18	8.68	43	24.52	68	96.95	93	381.04
19	8.78	44	25.74	69	101.97	94	412.58
20	9.07	45	27.08	70	107.04	95	447.36
21	9.39	46	28.51	71	112.14	96	485.64
22	9.74	47	30.00	72	117.31	97	527.69
23	10.13	48	31.61	73	122.59	98	573.77
24	10.52	49	33.30	74	128.00	99	624.19

Rates shown are guaranteed as long as you make the required premium payments. Underwritten by ReliaStar Life Insurance Company, policy form RL-WL2-POL-07 (may vary by state).

Example of Calculating Premium

Currently, you have \$25,500 of basic coverage under your group policy. Your current age is 35. You want to convert the entire amount. You want to be billed semi-annually.

Use the following steps to calculate your premium:

1. Determine the amount of coverage you wish to convert. **\$25,500**
2. Calculate the number of thousands you wish to convert by dividing the amount from step 1 by 1,000. **$\$25,500/1,000 = 25.5$**
3. Find the rate corresponding to your age at the time of conversion. **\$17.20**
4. Multiply the number of thousands from step 2 by the rate found in step 3. **$25.5 * \$17.20 = \438.60**
5. Find a policy fee corresponding to the amount of coverage from step 1. **\$12.00**
6. Add the policy fee to the amount in step 4. **$\$438.60 + \$12.00 = \$450.60$**
7. Multiply the amount in previous step by 0.265 for Quarterly billings, 0.515 for Semi-Annual billings, and 1 for Annual billings:
 $\$450.60 * 0.515 = \232.06

\$232.06 is your semi-annual premium.

POLICY FEES	
Converted Face Amount	Whole Life Insurance
\$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

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, both you and the financial organization 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 SECTION

After completing the top portion of this form, the form should be delivered or sent to the designated financial institution. Upon completion, you and the financial institution should retain a photocopy for your records and the original to NDPERS.

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



Underwritten by:
 Unum Life Insurance Company of America
 LTC Department
 2211 Congress Street, Portland, Maine 04122

**NORTH DAKOTA PUBLIC EMPLOYEES
 RETIREMENT SYSTEM
 Benefit Election Form
 Long Term Care - Policy #510487**

Your Name: (Last Name, First, Middle Initial)	Social Security Number ____-____-_____	Date of Birth (MM/DD/YYYY) ____/____/____
Street Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire (MM/DD/YYYY) ____/____/____
City, State, Zip Code	Home Telephone # ()	Work Telephone # ()

Complete the following only if applicant is not the employee

Employee's Name	Employee Social Security No. ____-____-_____	Employee Date of Birth ____/____/____	Employee Date of Hire ____/____/____
-----------------	---	--	---

Division (check one): State Central Payroll All Others

Applicant Is:

<input type="checkbox"/> Employee	<input type="checkbox"/> Retiree
<input type="checkbox"/> Employee's Spouse	<input type="checkbox"/> Retiree's Spouse

You may choose any of the plans listed below. The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

Plans (Check one)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Plan 1A
<input type="checkbox"/> Nursing Home Facility / \$3,000 Monthly Benefit
<input type="checkbox"/> Professional Home Care | <input type="checkbox"/> Plan 2A
<input type="checkbox"/> Nursing Home Facility / \$3,000 Monthly Benefit
<input type="checkbox"/> Professional Home Care
<input type="checkbox"/> Total Home Care | <input type="checkbox"/> Plan 3A
<input type="checkbox"/> Nursing Home Facility / \$3,000 Monthly Benefit
<input type="checkbox"/> Professional Home Care
<input type="checkbox"/> Simple Inflation | <input type="checkbox"/> Plan 4A
<input type="checkbox"/> Nursing Home Facility / \$3,000 Monthly Benefit
<input type="checkbox"/> Professional Home Care
<input type="checkbox"/> Total Home Care
<input type="checkbox"/> Simple Inflation |
| <input type="checkbox"/> Plan 1B
<input type="checkbox"/> Nursing Home Facility / \$3,000 Monthly Benefit
<input type="checkbox"/> Paid Up Benefit
<input type="checkbox"/> Professional Home Care | <input type="checkbox"/> Plan 2B
<input type="checkbox"/> Nursing Home Facility / \$3,000 Monthly Benefit
<input type="checkbox"/> Paid Up Benefit
<input type="checkbox"/> Professional Home Care
<input type="checkbox"/> Total Home Care | <input type="checkbox"/> Plan 3B
<input type="checkbox"/> Nursing Home Facility / \$3,000 Monthly Benefit
<input type="checkbox"/> Paid Up Benefit
<input type="checkbox"/> Professional Home Care
<input type="checkbox"/> Simple Inflation | <input type="checkbox"/> Plan 4B
<input type="checkbox"/> Nursing Home Facility / \$3,000 Monthly Benefit
<input type="checkbox"/> Paid Up Benefit
<input type="checkbox"/> Professional Home Care
<input type="checkbox"/> Total Home Care
<input type="checkbox"/> Simple Inflation |

Facility Benefit Duration (Duration of benefits may vary depending on where benefits are received.)

(Check one) 3 Years 5 Years

Active Employee or Spouse: Your premium will be paid through the Employee's payroll deduction. Employee must sign below to authorize the Employer to make the payroll deduction.

Retirees: Please select payment method: Monthly Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments), **OR**

Billed directly (paper) by the insurance company: Quarterly Semi-Annually Annually

Caution: If your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your coverage. **MA Residents ONLY:** You also signify that you have received and read the MassHealth eligibility notice entitled "For Massachusetts Residents Only"- Form #7650-04. All information is contained in your kit.

Your Premium: \$ _____ (Transfer the premium amount from the calculation on the rate sheet)

_____ Applicant's Signature	____/____/____ Date	_____ Employee's Signature (Required for Spouse Coverage)	____/____/____ Date
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Employees & Spouses: Please sign and mail all required signature forms to your employer.
Retirees: Please sign and mail all required signature forms to Unum (address at top of page).
 Retain a copy for your records. (A1)

If you have questions about Long Term Care coverage, please call Unum's toll-free number: 1-800-227-4165.



CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)
 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
 SFN 53512 (REV. 10-2010)

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		
<p>If you elect Medical Spending Continuation coverage, it will be in effect to the end of the current plan year, or December 31.</p> <p>Do you wish to continue your current participation in the NDPERS Flexcomp Plan Medical Spending Account? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> I wish to pre-pay the premium through the end of the plan year with pre-tax dollars deducted from my final pay checks.</p> <p><input type="checkbox"/> I will pay the premium plus a 2% administration fee with after-tax dollars through the remainder of the plan year.</p>		
PART C AUTHORIZATION OF APPLICANT		
<p>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.</p>		
<p>_____</p> <p>Applicant's Signature</p>		<p>_____</p> <p>Date of Signature</p>

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

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