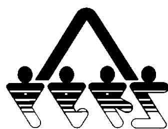


NOTICE OF TRANSFER

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53706 (Rev. 07-2010)

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)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth

PART B CURRENT EMPLOYER

Organization Name	NDPERS Organization ID
Last Date of Service with Current Agency	Date of Last Regular Paycheck
Last Month Insurance Premium(s) will be paid by your agency/or this employee (Month & Year) :	Projected Accumulated hours of sick leave to date of transfer:

PART C CURRENT PLAN INFORMATION (Check yes or no for all NDPERS plans the employee is currently participating in)

Plan	
Defined Benefit Plan	☐No ☐Yes
Defined Contribution Plan	☐No ☐Yes
Deferred Compensation (457)	☐No ☐Yes, Provider(s):________________________________ Monthly Deduction: $_________________ (if more than one provider- attach a detailed memo)
Group Health Insurance	☐No ☐Yes, ☐Single ☐Family
Group Life Insurance	☐No ☐Yes, ☐$1,300 Basic Life ☐Supplemental $_______________.00 ☐Dependent $_______________.00 ☐Spouse Supplemental $_______________.00
Group Dental Insurance	☐No ☐Yes, ☐Individual Only ☐Individual & Spouse ☐Individual & Child(ren) ☐Family
Group Vision Insurance	☐No ☐Yes, ☐Individual Only ☐Individual & Spouse ☐Individual & Child(ren) ☐Family
Long Term Care Insurance	☐No ☐Yes, Premiums: $_______________ Employee $_______________Spouse
FlexComp Plan	☐No ☐Yes, ☐Medical Spending, $_______________Annual Deduction ☐Dependent Care, $_______________Annual Deduction

PART D AUTHORIZATION OF CURRENT AUTHORIZED AGENT

I certify that the above information is true and correct.

Authorized Agent Signature	Telephone Number	Date of Signature

PART E NEW EMPLOYER

Organization Name	Department Number
First Day of Service with New Agency:	Date of First Regular Paycheck

New Classification:

☐Classified State	☐Non-Classified State	☐Non-State	☐Salaried	☐Hourly
☐Non-Seasonal	☐Seasonal	☐Elected Official	☐Appointed Official	
☐State Supreme Court	☐State University System	☐TIAA-CREF	☐ND Teacher's Fund for Retirement	

PART F AUTHORIZATION OF NEW AUTHORIZED AGENT

I certify that the above information is true and correct.

Authorized Agent Signature	Telephone Number	Date of Signature

INSTRUCTIONS

Often employees will terminate their position with an employer participating in NDPERS and take a job with another employer who is also participating in NDPERS (SEE **LISTING OF PARTICIPATING EMPLOYERS**). Therefore, the employee's membership is transferred to the new employer and membership IS NOT terminated unless the new employer does not offer or is not eligible for a particular NDPERS plan.

Part A Member Information

For member identification, please provide all requested information.

Part B Current Employer

A PERS Transfer Kit must be given to the employee to complete. **A completed kit must accompany the Notice of Transfer SFN 53706.**

Indicate the current employer's name and department number. Indicate the last day of employment and the last regular paycheck issued to the employee.

Indicate last month insurance premiums will be paid by your agency/employee.

Indicate the projected accumulated unused sick leave at the date of transfer.

Part C Current Plan Information

Check the appropriate box on the right side for all NDPERS plans. If the employee does not participate in a plan, check the NO box. If the employee does currently participate, check the YES box and complete all applicable boxes following, if any.

Part D Authorization of Authorized Agent

The current agency's designated NDPERS authorized agent must sign and date this form.

Part E New Employer

This form should be forwarded to the new employer. The new employer should indicate the agency's name and department number; as well as, the first day of employment and the employee's first regular paycheck.

The new employer should also indicate the employee's new job classification.

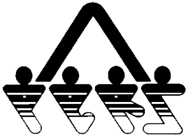
The new employer should transfer any eligible plan participation as indicated in Part C with NO change in the levels of coverage.

Any plans the employee currently participates in but not offered or eligible through new employment will be terminated.

Any plans the employee currently does not participate in but now is offered or eligible through new employment, the employer must enroll as a new employee. See your Inside NDPERS Handbook for instructions for enrolling a new employee.

Part F Authorization of Authorized Agent

The new agency's designated NDPERS authorized agent must sign and date this form.



TRANSFER OF UNUSED SICK LEAVE VERIFICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53404 (Rev. 07-2010)

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

PART B MEMBER AUTHORIZATION

I authorize the exchange of unused sick leave information between my Former Employer, New Employer, and the North Dakota Public Employees Retirement System.

I understand that a completed "Transfer of Unused Sick Leave Verification SFN 53404" MUST be on file at NDPERS within 60 days from the date I leave employment with my former employer.

I understand that upon my termination of employment, I will have the opportunity to convert my unused sick leave to service credit according the North Dakota Administrative Code Chapter 71-02-03-06.

______________________________	________________________
Member's Signature	Date of Signature

PART C FORMER EMPLOYER VERIFICATION	
Organization Name	NDPERS Organization ID
Total number of hours of unused sick leave at time of employment transfer: __________	
Signature of Authorized Agent	Date of Signature

PART D NEW EMPLOYER VERIFICATION	
Organization Name	NDPERS Organization ID
Total number of hours of unused sick leave **accepted**:	Total number of hours of unused sick leave **rejected**:
Signature of Authorized Agent	Date of Signature

INSTRUCTIONS

PART A - MEMBER INFORMATION

For member identification, please provide all requested information.

PART B – MEMBER AUTHORIZATION

Member must read authorization, provide signature and date. This will authorize the information to be exchanged between employers and NDPERS. Once signed, member should forward the form to their former employer for completion.

PART C – FORMER EMPLOYER VERIFICATION

Member's former employer must complete all information requested in Part C for the section to be valid. Once completed, former employer should forward the form to the new employer for completion.

PART D – NEW EMPLOYER VERIFICATION

Member's new employer must complete all information requested in Part D for the section to be valid. Once sections A-D are completed, the form should be forwarded to NDPERS for processing.

CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 14120 (Rev. 10-2011)

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

PART A APPLICANT INFORMATION

Name (Last, First, Middle)	Date of Birth	Last Four Digits of Social Security Number	
Address	City	State	Zip + 4
Relationship to current contract holder ☐ Self ☐ Spouse/Dependant	Gender ☐ Male ☐ Female	Telephone Number	
Name of current contract holder: (Last, First, Middle)		NDPERS Member Id	

PART B QUALIFYING COBRA EVENT

☐ Termination of current contract holder
☐ Divorce from current contract holder
☐ Death of current contract holder
☐ Married
☐ Attained Age 26
☐ Contract holder entitled to Medicare

Date of Event:

Select the coverage(s) to be continued, check level of coverage and list covered individuals.

☐ Health Insurance: ☐ Self Only ☐ Family ☐ Waive

☐ Dental Insurance: ☐ Self Only ☐ Family ☐ Applicant & Spouse ☐ Applicant & Child(ren) ☐ Waive

☐ Vision Insurance: ☐ Self Only ☐ Family ☐ Applicant & Spouse ☐ Applicant & Child(ren) ☐ Waive

Below list all eligible covered individuals for the plan listed above. Attach separate sheet if more room is needed. 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. Section 3402. The individual's social security number will be used for tax reporting and as an identification number.

Name (Last, First, Middle)	Relationship to Employee	Gender	Date of Birth	Social Security Number
	Self			
	Spouse			

PART C PAYMENT METHOD

PAYMENT OPTION ☐ Withhold from bank account (Complete 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.**

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, PERSLink Id and effective date. NDPERS must receive a cancellation request by the **15th** 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 D APPLICANT AUTHORIZATION

I have 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 constitute a fraudulent act or intentional misrepresentation and may void or retroactively cancel any benefit issued based on this application.

________________________ Signature of Applicant

________________ Date of Signature

.

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.

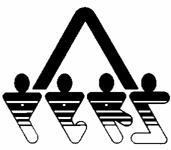
PART C PAYMENT METHOD

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



DENTAL/VISION INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58792 (Rev. 12-2011)

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

PART A MEMBER IDENTIFICATION

Employee Name (Last, First, Middle)		NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth	Daytime Telephone Number
Organization Name		NDPERS Organization ID
Date of Hire		Active in the Military? ☐No ☐Yes

PART B INSURANCE ELECTION

Effective Date of Change (MM-DD-YYYY):

Section 1 Reason for Change:

☐New Coverage (I do not have existing coverage)
☐Annual Enrollment
☐Cancel Coverage
☐Remove Dependent
☐Loss of Other Coverage
☐Transfer Employment:
from ____________________ to ____________________
☐Transfer from existing policy **(Complete Part D)**
☐Add Dependent: Is this an adult child? ☐No ☐Yes. Please answer the following questions.
Is adult child married? ☐No ☐Yes
Is adult child Disabled?☐No ☐Yes

Section 2 Level Of Coverage for Plan(s):

Dental Insurance

☐Single Coverage
☐Employee and Spouse
☐Employee and Child(ren)
☐Employee and Family

Vision Insurance

☐Single Coverage
☐Employee and Spouse
☐Employee and Child(ren)
☐Employee and Family

PART C DEPENDENT INFORMATION

1. List all family members to be covered under the plan **indicated in Part B, Section 2**, other than yourself.
   a. Indicate dependent's address below name if address is different from yours.
   b. For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
   c. For Marital Status, enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed
2. 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.

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. Section 3402. The individual's social security number will be used for tax reporting and as an identification number.

Dependent Name (last, first, middle) If address is different then subscriber, indicate address under name	Relationship	Gender	Date of Birth	Social Security Number	Marital Status	Court Ordered Coverage	Active Military
	Spouse					N/A	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes

PART D 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.**

Plan**	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:	

****For Plan, indicate type of coverage -- Dental, or Vision**

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

Person's Name	Injury Date (MM-DD-YY)	Type of Injury	Company Providing Benefits & Phone Number

PART E MEMBER AUTHORIZATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (front and back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively cancelling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

- I understand members are subject to limitations and exclusions outlined in the relevant Benefit Plan/Policy.
- I understand that in the event the group through which I am enrolled elects to terminate, the Insurance Carrier has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.
- I understand conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with the Insurance Carrier and has enrolled as a group with another Insurance Carrier.
- I understand, in the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit to NDPERS.

Please retain a copy of this Application for your records

______________________________ Member's Signature

______________________________ Date of Signature

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? ❐ Yes ❐ No	If "Yes", give date of disability	Does policy have waiver provision? ❐ Yes ❐ No	Was ownership assigned? ❐ Yes ❐ No

Initial insurance effective date (with ReliaStar)	Employment termination date	Insurance termination date (DO NOT include grace period)

Coverage terminating

❐ Employee
- Basic Amount .... $ ____________
- Supplemental/Voluntary amount . $ ____________
- Other .... $ ____________
- **Total amount eligible for conversion** $ ____________

❐ Dependent spouse
- Basic Amount .... $ ____________
- Supplemental/Voluntary amount . $ ____________
- Other .... $ ____________
- **Total amount eligible for conversion** $ ____________

❐ Dependent children (each)
- Basic Amount .... $ ____________
- Supplemental/Voluntary amount . $ ____________
- Other .... $ ____________
- **Total amount eligible for conversion** $ ____________

Reason for termination

❐ Termination of employment
❐ Termination of group policy
❐ Reduction of coverage
❐ Retirement
❐ Loss of Dependent Status
❐ Disabled
❐ Death of Employee
Spouse name____________
❐ Other (specify)____________

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

Signature (employer)	Title	Company phone number

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.

E-Ship: 147077 10/16/2008

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

LIFE INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53803 (Rev. 09-2011)

Underwritten by ING Employee Benefits (Carrier) Policy Number: 67389-7

PART A EMPLOYER/EMPLOYMENT STATUS

Organization Name	NDPERS Organization ID	Employment Status ☐ Active Full-Time ☐ Active Part-Time ☐ Retired

This Change is due to: (Check all that apply)
☐ New Hire (Date of Hire_____/_____/_____) ☐ Annual Enrollment-Read below for Evidence of Insurability (EOI) requirements
☐ Decrease Coverage ☐ Change of Beneficiary ☐ Marital Status Change (Date of Change _____/_____/_______)
☐ Birth/Adoption (Date of Change______/______/________)

Effective Date
______**/01/20**_____

PART B EMPLOYEE INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last 4 Digits of SSN	Date of Birth

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 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 qualifying event or annual enrollment, an Evidence of Insurability form (EOI) must be completed.

☐ **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 or 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.
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.
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.

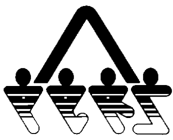
Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.
YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE

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.



LIFE INSURANCE DESIGNATION OF BENEFICIARY

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53855 (Rev. 06-2011)

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 • 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	Policy Number: 67389-7
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
☐ Married ☐ Single ☐ Divorced ☐ Widowed	
Effective Date:	

PART B DESIGNATION OF BENEFICIARY

Primary Beneficiary(ies) (If person enter: Last, First, Middle)	Relationship	Gender	Social Security Number	Birth Date	% Share	Address
				Must Equal 100%		

Contingent/Secondary Beneficiary(ies) (If person enter: Last, First, Middle)	Relationship	Gender	Social Security Number	Birth Date	% Share	Address
				Must Equal 100%		

PART C MEMBER AUTHORIZATION

I understand that this election revokes any previous life insurance beneficiary designations. 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 Signed

Part A Member Information

Enter your name, NDPERS ID number, date of birth, last four digits of your Social Security Number, marital status, and effective date of change.

Part B Designation of Beneficiary

1. Use full legal name. (Example: "Anna May Smith," not Mrs. John Smith")
2. A member may designate contingent beneficiary (ies) who will receive benefits if the primary beneficiary (ies) predecease member**.**
3. If more than one person in a class (primary or contingent beneficiary) is named, members of that class will share equally in the benefits unless specific shares are designated. The total number of shares must equal 100 percent. The benefit will be distributed as directed by the designation. If a named beneficiary does not survive, the beneficiary's share will be distributed among any surviving beneficiaries, in the same proportion as the initial shares.
4. To file a death claim, a certified copy of the Death Certificate must be provided to NDPERS to process the claim.
5. Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established, or as allowed by law.
6. If an estate is named, specify whose estate such as: "Estate of the Insured." Full name and address of the executor must be included.

TRUSTEE DESIGNATION:

1. Trustee under the last will and testament of the insured, or his/her successors in trust, PROVIDED, HOWEVER, that if no claim is made by the Trustee within one year from the date of death of the insured or if the insured shall die leaving no last will and testament containing the trust covering this policy, the proceeds shall be payable to the estate of the insured. Payment of the proceeds of this policy to said Trustee or successors in trust shall fully and finally discharge the Company from all liability.
2. "The _______________Trust Company, trustee under written trust agreement date (month, date, year) _____________, or its successor or successors in trust, and payment of the proceeds of this policy to said Trustee or successor or successors shall fully and finally discharge the Company from all liability." Full name and address of trust administrator must be included.

IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part C Member Authorization

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

AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 50134 (Rev. 12-2011)

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 MEMBER AUTHORIZATION

I authorize the following insurance premium(s) to be withheld from the Financial Institution indicated in Part B of this authorization:

☐ Health ☐ Life ☐ Dental ☐ Vision

This authorization will remain in effect until the member notifies NDPERS in writing to cancel it in such time as to afford NDPERS a reasonable opportunity to act on it. The premium amount will be deducted from the bank account by the fifth day of each month or the next working day if the fifth is on a weekend or a holiday. Your financial institution may charge an additional fee for this service.

I agree to the terms listed on this authorization.

_______________________________ Member Signature

_______________ Date

PART C FINANCIAL INSTITUTION (Must Be Completed By Institution)

Name of Financial Institution			
Mailing Address	City	State	Zip Code

Payee's Account Number	Type of Account ☐ Checking ☐ Savings

Routing Number (9 Digits) ☐☐☐☐☐☐☐☐☐

_______________________________ Signature of Financial Institution Representative

_______________ Date of Signature

Financial Institution Representative (Please Print)	Title	Telephone Number

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 ☐ Male ☐ 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:

☐ Employee	☐ Retiree
☐ Employee's Spouse	☐ 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)*

☐ **Plan 1A**
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care

☐ **Plan 2A**
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care
- Total Home Care

☐ **Plan 3A**
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care
- Simple Inflation

☐ **Plan 4A**
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care
- Total Home Care
- Simple Inflation

☐ **Plan 1B**
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care

☐ **Plan 2B**
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care
- Total Home Care

☐ **Plan 3B**
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care
- Simple Inflation

☐ **Plan 4B**
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care
- Total Home Care
- 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.

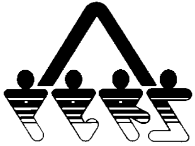
By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your 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*

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

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

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.

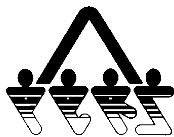
COBRA Coverage Premiums

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



457 DEFERRED COMPENSATION PLAN ENROLLMENT/CHANGE FORM

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 3803 (Rev. 12-2011)

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

PART A PARTICIPANT INFORMATION

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

PART B PROVIDER INFORMATION

Name of Company	
Agent Name	Telephone Number

PARTC CHECK ALL THAT APPLY

☐ 1. New Application
☐ 2. Increase Deduction
☐ 3. Decrease Deduction
☐ 4. Suspend Deduction (Includes going from full-time to part-time)
☐ 5. Change Employer: From: ______________________ To: _____________________
☐ 6. Age 50 or older: Annual Catch-up
☐ 7. Regular 3 Year Catch-up –**457 Deferred Compensation Catch-up Worksheet Certification SFN 51501 MUST accompany this form**
☐ 8. Provider Change **YOU MUST complete 2 Participant Agreement forms; one for the new provider, √ 'New Application' and one to stop contributions to old provider, √ 'Suspend Deduction'.**
☐ 9. Change in Agent only (Complete Part A, B & F)
☐ 10. USERRA Missed Contributions
☐ 11. Lump sum Sick & Annual Leave

PART D CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION

Must be completed if you checked 1, 2, 6, 7, 8, 10, or 11 in Part C

A. Annual Gross Pay $____________
B. Less Employer Retirement Contributions made under a IRC 414(h) arrangement (use most recent pay stub) $____________
C. Includable Compensation (subtract B from A) $____________
D. Maximum Annual Allowable Deduction:
D 1. Lesser of 100% of Includable Compensation or annual maximum limit (see annual limits on back of form)
Enter the lesser of D 1 but not less than the minimum annual deduction of $300.00 ($25.00) per month $____________
E. Age 50 + catch-up (see annual limits on back of form) $____________
F. Total D + E $____________
G. Pay Period Deduction (F divided by number of pay periods in calendar year) $____________

PART E SALARY REDUCTION AUTHORIZATION.

Must be completed if you checked 1, 2, 6, 7, 8, 10, or 11 in Part C

Authorization for deductions must be made in the month prior to the pay period in which the income is earned.
I authorize my employer to reduce my salary in the amount of $_______________ for the pay period beginning date **(not date paid)** __________________.
(The signature date in Part F must be in the month prior to the pay period date entered here.) (month, day, year)

With regard to this agreement, the Participant acknowledges the following (read and initial each statement):

_______ I understand that my salary will be reduced each pay period by the amount authorized above. The deduction can not be changed or stopped without an authorized participant agreement form returned to payroll from NDPERS.
_______ I understand the accumulated deferred salary is credited to my account and is not available to me or my beneficiary(ies) until I separate from service, unless, I should experience an unforeseeable emergency and a distribution is approved by the NDPERS Board. .
_______ I acknowledge that the Retirement Board makes no recommendation as to any provider and understand that the Retirement Board does not warrant or guarantee the investment performance of any provider.
_______ I understand that all compensation deferred under the Plan, and all earnings accruing thereof, shall be held for the exclusive benefit of myself or my Beneficiary, until such time as it is made available to me pursuant to the terms of the Plan.
_______ I understand that this agreement includes the beneficiary forms as executed with and maintained by my provider.

PART F PARTICIPANT AUTHORIZATION

I verify that the foregoing statements are true and correct to the best of my knowledge and belief, and are subject to the laws and penalties governing any misrepresentations and fraud.

_______________________________________ _______________
Participant Authorization Date

(This date must be in the month prior to the date entered in Part E)

ANNUAL LIMITS

Annual Limit for 2012 : $17,000
Age 50+ Limit for2012: $22,500
Regular 3 Year Catchup: $34,000

PART A PARTICIPANT INFORMATION

For member identification, please provide all requested information.

PART B PROVIDER INFORMATION

If you check 'New Application in Part C, you must first select and contact one of the eligible providers for the plan. The provider representative you select will assist you in completing the required forms to open an account.

PART C CHECK ALL THAT APPLY

Check the applicable box(s).

PART D CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION

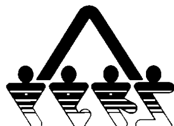
The minimum contribution is $25.00 per month. The maximum regular annual contribution limit is the lesser of 100% of annual compensation or the annual maximum limit indicated above.

PART E SALARY REDUCTION AUTHORIZATION

The IRS regulations require you to make your deferral election in the month prior to the month the salary is earned.

PART F PARTICIPANT AUTHORIZATION

Sign where indicated. If you completed Part E, your signature must be dated in the month prior to the month entered in that section.



457 DEFERRED COMPENSATION PLAN EXPEDITED ENROLLMENT/WAIVER

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 54362 (Rev. 06-2011)

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

PART A EMPLOYEE INFORMATION

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

PART B EXPEDITED DEFERRED COMP PLAN & PEP ENROLLMENT

I understand that by electing to begin participation in the 457 Deferred Compensation Plan, I will reduce my wages by $25.00 **a month** and vest in the employer's contributions to the Defined Benefit Retirement Plan, to which I am entitled based on my service credit and level of contribution (See vesting schedule on back of form). My contributions will be invested with the NDPERS Companion Plan.

(The minimum of $25.00 is paid at $12.50 per pay period for bi-weekly and semi-monthly payrolls.)

I authorize my employer to reduce my salary by $25.00 a month for pay period date beginning ______/_____/_____.
Month / Day / Year

_______________________________ Participant Authorization

_________________________ Date

PART C PARTICIPANT ACKNOWLEDGEMENT

With regard to this agreement, the Participant acknowledges the following (read and initial each statement).

____ I understand that **by electing to participate**, **my salary will be reduced by $25.00 per month**.
____ I understand that by participating in the deferred compensation plan and the NDPERS defined benefit retirement plan I am automatically enrolled in PEP and the applicable employer contribution is credited to my NDPERS member account.
____ I acknowledge that I have the right to increase or decrease the amount of contribution, change to another Provider company or suspend contributions at any time by completing the Participant Agreement for Salary Reduction form (SFN 3803).
____ I understand that the accumulated deferred salary is not available to me until I separate from service, or when I experience an approved unforeseeable emergency.
____ I acknowledge that the NDPERS Board makes no recommendation as to any fund investment and I understand that the NDPERS Board does not warrant or guarantee the investment performance of the funds offered by any provider.
____ I understand that all compensation deferred under the Plan, and all earnings accruing thereof, shall be held for the exclusive benefit of myself or my beneficiary, until such time as it is made available to me pursuant to the terms of the Plan.

PART D WAIVER OF PARTICIPATION

I understand that by declining to participate in the 457 Plan at this time, I **will not vest in the employer's contributions** to the Defined Benefit Retirement Plan, to which I am entitled, based on my service credit. I understand that I am eligible to begin participation at a later date and will automatically vest in the employer's contribution when I participate in a deferred compensation plan.

I elect to decline to participate at this time.

_______________________________ Participant Authorization

_________________________ Date

This form only applies if your employer participates in the Defined Benefit Retirement Plan

By electing to enroll in the Deferred Compensation Program through your employer at a minimum required monthly contribution of $25.00, you automatically enroll in the Portability Enhancement Provision (PEP) for the NDPERS Defined Benefit Retirement Plan. Your NDPERS retirement account will automatically be credited with the percentage of the employer contribution to which you are entitled based upon your years of credited service. As you attain additional service credit, you must increase your 457 contribution amount to the corresponding percentage of salary to achieve maximum vesting.

Service Credit	Minimum Contribution	Maximum Vesting %
0-12 Months	$25	1%
13-24 Months	$25	2%
25-36 Months	$25	3%
37+ Months	$25	4%

INSTRUCTIONS:

PART A: EMPLOYEE INFORMATION

This form must be completed regardless of whether the employee elects to participate or declines to participate in the 457 Deferred Compensation Plan and Portability Enhancement Provision (PEP).

For member identification, please provide all requested information.

Part B: EXPEDITED ENROLLMENT IN DEFERRED COMP/PEP

This section should be completed if the employee elects to participate in the Deferred Compensation Plan and the Portability Enhancement Provision (PEP). The employee's signature in this section **will authorize** a reduction in the employee monthly wage and contribution to a deferred compensation plan. The minimum of $25.00 is paid at $12.50 per pay period for bi-weekly and semi-monthly payrolls.

The employee must sign and date this section.

PART C: PARTICIPANT ACKNOWLEDGEMENT

The employee must read each item and indicate acknowledgement by initialing all boxes on the left side of the statements.

Part D: WAIVER OF PARTICIPATION

The employee must sign and date this section only if the **employee waives participation** in the Deferred Compensation Plan.