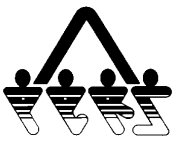


ESTIMATED BENEFIT PAYMENT REQUEST

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.

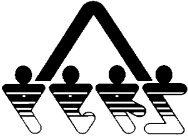
Dental Insurance:
If you elect to continue or apply for NDPERS group dental insurance coverage, select level of coverage.

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 DEFINED BENEFIT PLAN MONTHLY PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 2562 (Rev. 12-2009)

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657

(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A PARTICIPANT IDENTIFICATION

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

PART B APPLICATION FOR RETIREMENT BENEFITS & RETIREE HEALTH INSURANCE CREDITS

NDPERS Retirement Effective (Month / 1 / Year) __________/ 1 /__________

MainSystem, Law Enforcement, National Guard	**Highway Patrol, Judges**

SECTION 1 RETIREMENT OPTION (Check One)

MainSystem, Law Enforcement, National Guard

- ☐ MainSystem Early Retirement (Age 55-64)
- ☐ Law Enforcement/National Guard Early Retirement (Age 50-55)
- ☐ MainSystem Normal Retirement (Rule of 85 OR Age 65 & Over)
- ☐ Law Enforcement Normal Retirement (Rule of 85 OR Age 55 & Over)
- ☐ National Guard Normal Retirement (Age 55 & Over)

Highway Patrol, Judges

- ☐ Highway Patrol Early Retirement (Age 50-55)
- ☐ Judges Early Retirement (Age 55-64)
- ☐ Highway Normal Retirement (Rule of 80 OR Age 55 & Over)
- ☐ Judges Normal Retirement (Rule of 85 OR Age 65 & Over)

SECTION 2 RETIREMENT PAYMENT OPTION (Check One)

MainSystem, Law Enforcement, National Guard

- ☐ Single Life
- ☐ 50% Joint Survivor/Life ☐ 100% Joint Survivor/Life
- ☐ 10 Year Term Certain/Life ☐ 20 Year Term Certain/Life
- ☐ Social Security Level Income: (Check One Age Below)
  - ☐ Age 62 ☐ ______ other age
  - ☐ Social Security Normal Retirement Age

Highway Patrol, Judges

- ☐ Normal Retirement
- ☐ 100% Joint Survivor/Life
- ☐ 10 Year Term Certain/Life ☐ 20 Year Term Certain/Life
- ☐ Social Security Level Income (Judges Only):
  - (Check One Age) ☐ Age 62 ☐ ______ other age
  - ☐ Social Security Normal Retirement Age

SECTION 3 RETIREE HEALTH INSURANCE CREDIT OPTIONS (Check One)

☐ I elect the standard retiree health insurance credit option specific to the retirement option selected in section 2.

☐ 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 insurance credit option: (Check One Option Below)

☐ 50% Joint Survivor Life ☐ 100% Joint Survivor Life

PART C SICK LEAVE CONVERSION (Excluding Judges)

Do you wish to purchase all or part of your unused sick leave into retirement service credit? ☐ No ☐ Yes

If Yes, complete and return the Conversion Of Unused Sick Leave Application – Defined Benefit SFN 58358.

PART D AUTHORIZATION

I elect to receive the retirement benefits and health credit as indicated in PART B. I understand I must submit a photocopy of my birth certificate. **(If married, also submit a photocopy of spouse's birth certificate & marriage certificate.) I understand that this "APPLICATION FOR DEFINED BENEFIT PLAN MONTHLY PAYMENTS SFN 2562" must be received by NDPERS at least 30 days before distribution of my first retirement check.**

______________________________ ______________________

Member's Signature Date

Please refer to the "Group Retirement Plan" information sheet.

Part A Participant Identification

For member identification, please provide all requested information.

Part B Application for Retirement Benefits and Retiree Health Insurance Credits

Enter the month and year you want your retirement benefits to begin. Your NDPERS retirement effective date will be the first of the month following your last date of service or last date of pay, whichever is later. Your actual payment is the month following your effective date.

If you participate in the MainSystem, Law Enforcement, or National Guard retirement plan, complete the left side of Part B. If you participate in the Highway Patrol or Judges retirement plan, complete the right side of Part B.

Section 1: Indicate if you are an early retiree or a retiree meeting your normal retirement.

Section 2: Check your retirement payment option. Once you elect your payment option and start drawing a pension, the election becomes irrevocable. The only exception is if your spouse passes away and you are drawing benefits under a Joint & Survivor/Life payment option.

Section 3: Check your retiree health insurance credit option. You must make an election even though you may not be currently participating in the NDPERS group health insurance plan.

If you are drawing a pension and are enrolled in the Dakota Plan or Dakota Retiree Plan, this retiree health insurance credit will be applied towards the premium.

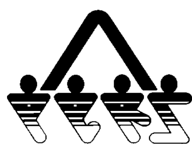
Part C: Sick Leave Conversion

This section is to be completed ONLY if you participate in the MainSystem, Law Enforcement, National Guard, and Highway Patrol retirement plan. Members of the Judges retirement plan are not eligible to purchase unused sick leave.

Part D: Authorization

You must provide a legible photocopy of your birth certificate and if married, your spouse's birth certificate and marriage certificate.

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



APPLICATION FOR DEFINED CONTRIBUTION PLAN PERIODIC PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 59045 (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 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 FOR RETIREMENT BENEFITS AND RETIREE HEALTH INSURNCE CREDITS

NDPERS Retirement Effective (Month / 1 / Year) __________/ 1 /__________

SECTION 1 RETIREMENT PAYMENT OPTION

☒ Periodic Retirement Payment.

A TIAA-CREF Distribution Form MUST be completed and accompany this application.

SECTION 2 RETIREE HEALTH CREDIT OPTIONS (Check One)

☐ I elect the standard retiree health insurance credit option.

☐ If married I understand that I have the option to elect the following alternate actuarially reduced retiree health insurance credit option, I elect: (Check One) ☐ 50% Joint Survivor Life ☐ 100% Joint Survivor Life

PART C AUTHORIZATION

I elect to receive the retirement benefits and health insurance credit as indicated in PART B. I understand I must submit a photocopy of my birth certificate. **(If married, also submit a photocopy of spouse's birth certificate & marriage certificate.)**

I understand that this "APPLICATION FOR DEFINED CONTRIBUTION PLAN PERIODIC PAYMENTS SFN 59045" must be received by NDPERS at least 30 days before distribution of my first retirement payment.

_______________________________ _______________

Member's Signature Date

Please refer to the "Group Retirement Plan" information sheet.

Part A Participant Identification

For member identification, please provide all requested information.

Part B Application for Retirement Benefits and Retiree Health Insurance Credits

Enter the month and year you want your retirement benefits to begin. Your NDPERS retirement effective date will be the first of the month following your last date of service or last date of pay, whichever is later. Your actual payment is the month following your effective date.

Section 1: This application is for periodic payments only. Your vested Account balance may be paid to you in monthly, quarterly, semiannual or annual periodic payments until your account is exhausted.

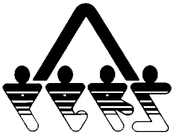
Section 2: Check your retiree health insurance credit option. You must make an election even though you may not be currently participating in the NDPERS group health insurance plan. This retiree health insurance credit can only be used if:

1. You participate in the NDPERS Dakota Plan (the NDPERS Group Health Insurance Plan),
2. You are drawing a periodic payment from the NDPERS Defined Contribution Plan, and
3. You are at least 55 years old or meet the Rule of 85.

Part C: Authorization

You must provide a legible photocopy of your birth certificate and if married, your spouse's birth certificate and marriage certificate.

YOU MUST SIGN AND DATE PART C 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 INDENTIFICATION

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

PART B NOTICE TO MEMBER

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

PART C HOURS OF UNUSED SICK LEAVE

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

PART D APPLICATION FOR AFTER TAX PAYMENT THROUGH PERSONAL CHECK

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

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

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

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

Indicate Month(s) and Projected Salary

Month	Year	Indicate Projected Gross Salary
		$
		$
		$

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

_______________________________ _______________________

Signature of Authorized Agent Date

PART G MEMBER ELECTION

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

_______________________________ _______________________

Signature of Member Date

INSTRUCTIONS

PART A PARTICIPANT IDENTIFICATION

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

PART B NOTICE OF MEMBER

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

PART C HOURS OF UNUSED SICK LEAVE

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

PART D APPLICATION FOR AFTER TAX PAYMENT THROUGH PERSONAL CHECK

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

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

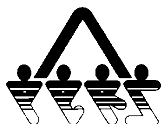
Complete this section to authorize a payment for your unused sick leave through a direct rollover/transfer from an eligible fund source.

PART F MEMBER ELECTION

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

PART G MEMBER ELECTION

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



APPLICATION FOR THE PARTIAL LUMP SUM OPTION – DEFINED BENEFIT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 54373 (Rev. 12-2009)

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

The Partial Lump Sum Option (PLSO) is NOT available to early and disabled retirees, or surviving spouses. The PLSO allows you to take a partial lump sum distribution equal to 12 monthly payments determined under the Single Life/Normal benefit option. (No variations will be accepted). If this option is elected, your monthly benefit will be actuarially reduced. You will still be permitted to choose one of the optional forms of payment for your ongoing monthly benefit with exception of the Level Social Security Income option. In addition, the PLSO payment, as well as your ongoing monthly benefits, will be subtracted from your individual minimum guarantee.

This option is a once in a life time election and made at the time of your initial retirement. You may not make an election after receiving your first retirement check nor apply for a second PLSO upon subsequent reemployment and retirement.

Please read the **"Special Tax Notice Regarding Plan Payments"** before continuing. Under Federal law, NDPERS is required to provide this information a minimum of 30 days prior to a distribution. This may affect the date of your PLSO payment.

PART C APPLICATION FOR PARTIAL LUMP SUM PAYMENT (PAID TO MEMBER)

1. ☐Check this box if you wish to elect a lump sum payment payable to you minus 20% for Federal income tax.

2. Please indicate if you want NDPERS to withhold North Dakota State income tax. If you DO NOT indicate your preference, ND State income tax will be automatically withheld. After a lump sum payment is issued, any adjustments to Federal or State income tax paid is the responsibility of the taxpayer. Check One: ☐Yes- Withhold North Dakota State Income Tax
☐No – DO NOT Withhold North Dakota State Income Tax

PART D APPLICATION FOR PARTIAL LUMP SUM PAYMENT (DIRECT ROLLOVER)

☐Check this box if you wish to have a direct rollover of your PLSO.

Please have a letter of acceptance forwarded to NDPERS from the financial institution. If any portion of your PLSO includes non-taxable income, then the letter of acceptance <u>is required</u> before your request will be processed.

Make Check Payable To (Financial Institution):			
Member's Account Number with Receiving Institution (If Available):			
Mailing Address of Financial Institution:	City	State	Zip + 4 Code

Portion to be rolled over:
☐All of my taxable income ☐_______ % of my account ☐All of my taxable & non-taxable income ☐$______ of my account

If no election is indicated, then NDPERS will automatically roll over 100% of your taxable income to your designated financial institution. Any non-taxable income will be mailed to you.

My NDPERS benefits are being rolled into (choose one): ☐A Defined Contribution Plan ☐A Traditional IRA

PART E AUTHORIZATION

I have reviewed and understand the above provisions, and hereby elect the Partial Lump Sum Option. I understand my election is irrevocable and that the Partial Lump Sum option is a once in a life-time election.

_______________________________________ _________________________

Signature of Member Date

INSTRUCTIONS

PART A PARTICIPANT IDENTIFICATION

For member identification, please provide all requested information.

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 APPLICATION FOR PARTIAL LUMP SUM PAYMENT (PAID TO MEMBER)

Complete this section to authorize a Partial Lump Sum Payment paid direct to you.

Payments are subject to Federal and ND State income tax. NDPERS is required to withhold Federal income tax; however, you may authorize NDPERS to withhold ND State income tax from your payment. If no preference is indicated, NDPERS will automatically withhold 3.92% of the taxable portion of your payment. After a payment is issued, any adjustments to Federal or State income tax paid will be your responsibility.

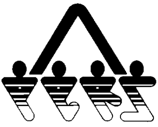
PART D APPLICATION FOR PARTIAL LUMP SUM PAYMENT (DIRECT ROLLOVER)

Complete this section to authorize a Partial Lump Sum Payment as a direct rollover.

1. Enter the name of the plan or financial institution accepting the direct rollover **(i.e. who the check should be made payable to - who will endorse the check)**. Please have your plan or financial institution forward a letter of acceptance of funds to NDPERS. If any portion of your rollover is non-taxable income, this will be required before your rollover is completed.
2. Enter your account number with the plan or financial institution where your funds will be rolled over.
3. Enter the full mailing address to which the direct rollover payment should be mailed. **DO NOT LIST YOUR PERSONAL MAILING ADDRESS: NDPERS CAN NOT SEND A DIRECT ROLLOVER TO A MEMBER'S HOME.**
4. Indicate how much of the income should be directly rolled over. If no election is indicated, NDPERS will automatically roll over 100% of your taxable income to your designated financial institution and mail any nontaxable income directly to you.
5. Check if your retirement fund is being rolled over into a Defined Contribution plan or a Traditional IRA.

PART E AUTHORIZATION

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



APPLICATION FOR THE GRADUATED BENEFIT OPTION – DEFINED BENEFIT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 59596 (Rev. 08-2010)

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

The Graduated Benefit Option is NOT available to early and disabled retirees, or surviving spouses. The Graduated Benefit Option allows you to select either a one percent or two percent annual benefit increase. (No variations will be accepted). If this option is elected, your monthly benefit will be actuarially reduced. You will still be permitted to choose one of the optional forms of payment for your ongoing monthly benefit with exception of the Level Social Security Income option, Partial Lump Sum option, and Deferred Normal Retirement option.

This option is a once in a life time election and made at the time of your initial retirement. You may not make an election after receiving your initial benefit payment. If you return to work, your Graduated Benefit Option will be applied to your subsequent retirement.

PART C APPLICATION FOR GRADUCATED BENEFIT OPTION

1. ☐ Check this box if you wish to elect the graduated benefit with an annual one (1) percent benefit increase.

2. ☐ Check this box if you wish to elect the graduated benefit with an annual two (2) percent benefit increase.

PART D AUTHORIZATION

I have reviewed and understand the above provisions. I understand that the Graduated Benefit Option is a once in a life-time election and my election is irrevocable.

_______________________________ _______________________

Signature of Member Date

INSTRUCTIONS

PART A PARTICIPANT IDENTIFICATION

For member identification, please provide all requested information.

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 APPLICATION FOR GRADUATED BENEFIT OPTION

Complete this section to authorize NDPERS to actuarially reduce your monthly benefit payment to provide for an annual one or two percent benefit increase.

PART D AUTHORIZATION

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

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)	☐Married ☐Single ☐Divorced ☐Widowed	NDPERS ID:
Date of Birth	Last Four Digits of Social Security Number:	
Spouse Name (Last, First, Middle)	Spouse Gender: ☐Male ☐Female	

PART B PRIMARY BENEFICIARY (IES) – Complete all sections

Name	Relationship	Social Security Number	Birth Date	% Share	Address
			Total must equal	**100%**	

PART C CONTINGENT/SECONDARY BENEFICIARY(IES)

Name	Relationship	Social Security Number	Birth Date	% Share	Address
			Total must equal	**100%**	

PART D MEMBER AUTHORIZATION

I understand that this election revokes any previous retirement account beneficiary designations. I understand that, if married, any initiation of dissolution or annulment of my marriage may void this designation. I have read and understand the terms and conditions listed on page two (2) of this designation. I hereby certify that the information provided on this form is true and correct to the best of my knowledge.

______________________________ Member Signature

______________________________ Date of Signature

PART E SPOUSE AUTHORIZATION

IF YOU ARE MARRIED AND DESIGNATE A BENEFICIARY OTHER THAN OR IN ADDITION TO YOUR SPOUSE, YOUR SPOUSE MUST COMPLETE THIS SECTION

If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to the listed beneficiary (ies).

If a member with three or more years of credited service is married, North Dakota law requires the spouse's consent before benefits can be paid other than to the member's spouse. (NDCC 30.1-05-02). If spouse's consent is given, please be advised, that if your primary beneficiary election is someone in addition to or in lieu of your spouse, there is no monthly pre-retirement death benefit provision.

I consent to the above retirement beneficiary (ies) designated by the above named NDPERS member.

______________________________ Spouse Signature

______________________________ Date of Signature

PROVISIONS FOR ALL BENEFITS

1. This "Designation of Beneficiary" is for the group Retirement Plan only. To designate beneficiary (ies) for the group Life Insurance Plan, please complete a “Life Designation of Beneficiary SFN 53855”.

2. **EFFECTIVE WHEN FILED:** This designation will be effective when properly executed and received in the NDPERS office.

3. **SUBJECT TO LAWS AND REGULATIONS:** This designation is subject to the governing statutes and to rules and regulations established by the Retirement Board of the North Dakota Public Employees Retirement System. The acceptance of the designation by NDPERS does not establish that a survivor benefit will be payable. Whether or not a benefit is payable and the amount thereof will be determined at the time of death under laws and regulations then applicable.

4. **WHO IS ELIGIBLE TO BE A BENEFICIARY:** Any person, whether or not a relative, or a church or charity may be designated as a primary or contingent beneficiary. A member may also designate his or her estate as beneficiary and the benefits will be distributed according to his or her testamentary will or according to the state laws for interstate distribution. A creditor of a member (such as a bank, credit union, loan company, etc.) may not be named a beneficiary as a means of providing security for a debt. (N.D.C.C. 28-22-19)

5. **DESIGNATED BENEFICIARIES:** All beneficiary designations shall equal 100% of the benefit. If the benefit is being divided amongst multiple beneficiaries and the total share does not equal 100%, NDPERS shall amend the designations in order to reach the 100% in total, but in no circumstance will PERS amend the beneficiary designation by more than one (1) %. If an amendment is necessary, the additional percentage shall be credited to the eldest beneficiary.

   If shares are not designated, NDPERS will distribute benefits equally to the named beneficiary (ies). As this distribution may not reflect the member’s preference, we recommend the member be sure to designate the percent of share for each listed beneficiary.

6. If there are no surviving beneficiaries, all benefits will be paid to your estate.

7. A **certified** copy of the death certificate must be sent to NDPERS to process a claim.

PROVISIONS FOR RETIREMENT BENEFITS ONLY

1. **DEATH OF ACTIVELY EMPLOYED MEMBER:**

   A. If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to whoever is the listed beneficiary(ies).

   B. If a member dies after completing three years of service, his/her retirement account will be distributed pursuant to N.D.C.C. 54-52-17(6) and N.D.C.C. 39-03.1-11(6).

2. **DEATH OF RETIREE:** Benefits will be paid to the named beneficiary based upon the option selected by the member at retirement. If there are no surviving beneficiaries, any remaining cash value will be paid to your estate.

3. **DEATH OF SURVIVING SPOUSE:** 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.

NOTE: Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established.

AUTHORIZATION FOR DIRECT DEPOSIT FOR ANNUITY PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 18379 (Rev. 07-2010)

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 AUTHORIZATION

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

I authorize the North Dakota Public Employees Retirement System (NDPERS) and the financial institution named on this form to initiate electronic fund transfer (EFT) of my retirement benefit(s) into my account as indicated below. I consent to the financial institution sharing my customer information with NDPERS for the purpose of completing the EFT arrangement.

Amount: ☐100% ☐__________% ☐$______________

☐ Checking Account Number: ______________________________

☐ Savings Account Number: ______________________________

This authorization will remain in effect until I notify NDPERS in writing to cancel it in such time as to afford NDPERS a reasonable opportunity to act on it.

I agree to the terms listed on this authorization.

______________________________ ______________
Signature of Annuitant/Payee Date

PART B FINANCIAL INSTITUTION (Must Be Completed By Institution/Bank)

Name of Financial Institution

Mailing Address	City	State	Zip Code

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

Routing Number (9 Digits)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

We, the financial institution named on this form, agree to receive and deposit sums for the payee. We agree to notify NDPERS upon becoming aware of the death of the payee.

The payee has the right to cancel this authorization, and we reserve the right to cancel this agreement by written notice to the payee. NDPERS retains the right to reclaim all amounts paid in error to the member or authorized financial institution.

______________________________ ______________
Signature of Financial Institution Representative Date of Signature

Financial Institution Representative (Please Print)	Title	Telephone Number

INSTRUCTIONS AND CONDITIONS

IMPORTANT NOTICE - This form is to be used only for North Dakota Public Employees Retirement System Benefit Payments.

If you wish your retirement benefit payment(s) sent to your financial organization for deposit into 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 forward these payments to the point you authorize. The financial organization may be any bank, savings bank, savings and loan association or similar institution, or Federal or State chartered credit union.

THIS FORM ONLY AUTHORIZES DEPOSITS INTO YOUR ACCOUNT.
IT DOES NOT AUTHORIZE WITHDRAWALS FROM YOUR ACCOUNT.

PART A PARTICIPANT AUTHORIZATION

LINE 1 – For member identification, please provide all requested information.

LINE 2 – Check if you want 100% or a portion of your benefit to be direct deposited in the financial institution indicated in Part B.

LINE 3 - Check the type of account and print account number for the account in which this payment is to be deposited.

LINE 4 - Sign and date the form.

PART B 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 is to be sent to the address at the top of this form.

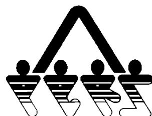
CANCELLATION INSTRUCTIONS

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.

FINANCIAL INSTITUTION

Immediate credit will be given the first working day of each month through your correspondent bank account at the Bank of North Dakota.



WITHHOLDING ALLOWANCE ELECTION FOR PENSION PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 51506 (Rev. 07-2010)

NDPERS • PO Box 1657 • Bismarck • ND 58502-1657
1-800- 803-7377 • 701- 328-3900 • 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 INSTRUCTIONS

Tax Withholding is calculated for each account separately. File one form for each account you may have. Check One:

☐Main Retirement Plan ☐Defined Contribution ☐Law Enforcement ☐National Guard ☐Judge ☐Highway Patrol

☐Surviving Spouse Account ☐Job Service

Effective Date:

PART C FEDERAL WITHHOLDING ALLOWANCE

☐ 1. I elect NOT to have federal income tax withheld from each periodic pension payment (Do not complete lines 2 or 3.)

☐ 2. 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 dollar amount.)

Step 1: Check marital status:
☐Single ☐Married ☐Married, but withholding at the higher Single rate

Step 2: Enter number of allowances → ______________

☐I want the following additional amount withheld from each periodic pension payment. (You cannot enter an amount here unless you complete line 2.) .... $ ____________

PART D NORTH DAKOTA STATE INCOME TAX WITHHOLDING

☐ 1. I elect NOT to have North Dakota State income tax withheld from each periodic pension payment (Do not complete lines 2 or 3.)

☐ 2. I want North Dakota 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 dollar amount.)

Step 1: Check marital status:
☐Single ☐Married ☐Married, but withholding at the higher Single rate

Step 2: Enter number of allowances → ______________

☐I want the following additional amount withheld from each periodic pension payment. .... $ ____________

PART E MEMBER AUTHORIZATION

Member's Signature	Date of Signature

This form is available in an IRS format upon request.

Your benefits from NDPERS are subject to federal and North Dakota State income tax withholding. Use this form to inform NDPERS of your income tax withholding election. The amount withheld will automatically change as the federal tax rates are adjusted each year.

Once you make an election, it will remain in effect until you change or revoke it. You must file a new form to change your filing status and/or the number of exemptions used in determining the amount being withheld from your pension benefit.

If you choose not to have tax withheld or do not have enough tax withheld, you may have to make estimated 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.

If you do not complete a Withholding Allowance Election for Pension Payments SFN 51506, NDPERS is required to withhold federal income tax as though you are married with three (3) withholding allowances. We are not required to withhold North Dakota state income tax.

Federal Income Tax Withholding

1. You can elect not to have income tax withheld by checking the box in section 1.
2. You can have federal income tax withheld based on the IRS tax table by checking and completing section 2. For federal income tax purposes, the amount of withholding is based on the marital status and the number of allowances (including zero) you identify on this form. You can also have an additional amount withheld from your NDPERS pension payment by checking and completing area provided under Step 2.

If no boxes are checked, your current federal withholding allowance and status will remain unchanged.

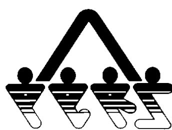
North Dakota Income Tax Withholding

For North Dakota residents, your NDPERS pension benefit is subject to state income taxes. If you are not a North Dakota resident, the benefits are taxable in the state in which you live.

1. You can elect not to have income tax withheld by checking the box in section 1.
2. You can have North Dakota State income tax withheld based on the IRS tax table by checking and completing section 2. For North Dakota State income tax purposes, the amount of withholding is based on the marital status and the number of allowances (including zero) you identify on this form. You can also have an additional amount withheld from your NDPERS pension payment by checking and completing area provided under Step 2.

If no boxes are checked, your current North Dakota State withholding allowance and status will remain unchanged.

Personal income tax questions should be directed to your tax advisor, accountant, or the Internal Revenue Service Center.



RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53799 (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 MEMBER INFORMATION	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth

PART B NDPERS GROUP HEALTH INSURANCE

Do you wish to continue your current coverage in the NDPERS Group Health Insurance Plan? ☐ No ☐ Yes

If Yes at: ☐ Current Level of Coverage; indicate level of coverage: ☐Single ☐Family of 2 ☐ Family of 3 or more

☐ Reduced Level of Coverage (Self Only) (**SFN 16277 MUST accompany this form)**

Employees terminating employment, or otherwise losing eligibility, may continue their NDPERS Group Health Coverage at their own expense for a maximum of 18 months subject to the following:

1) You must be a member of the plan at time of loss of eligibility.
2) Your spouse or any other dependent(s) applying for this continuation coverage must be a member of the plan at time of loss of eligibility.
3) You must complete and submit this election form to NDPERS within 60 days from your last date of coverage.

If you do not choose continuation coverage, your group health coverage will end on the last day of the month for which premiums were paid.

PART C PAYMENT METHOD

DO NOT SEND MONEY WITH THIS FORM. If a payment method is not elected, you will be billed for the premium due. 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 health coverage.

CANCELLATION POLICY

To cancel NDPERS health coverage, a written request must be submitted. The request must provide the contract holder's name, social security number 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.

RETIREMENT GROUP	**PAYMENT OPTION – MUST SELECT ONE**
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE →	☐ Deduct from pension check ☐ Withhold from bank account (Complete SFN 50134)
☐ TIAA-CREF ☐ NDPERS DEFINED CONTRIBUTION → ☐ EX-LEGISLATOR	☐ Withhold from bank account (Complete SFN 50134)

PART D MEMBER 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 void any benefit plans insured based on this application.

____________________________ ____________________

Signature of Member Date

PART A MEMBER INFORMATION

For member identification, complete all requested information.

PART B NDPERS GROUP HEALTH INSURANCE

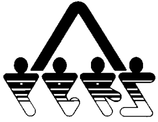
If continuing coverage, indicate the level of coverage. If continuing insurance, but a reduced level of coverage then the NDPERS Group Health Application must accompany this application.

PART C PAYMENT METHOD

If continuing coverage, indicate which retirement group you are receiving benefits from and your method of payment.

PART D MEMBER AUTHORIZATION

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



RETIREE GROUP HEALTH INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 16277 (Rev. 05-2011)

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A MEMBER INFORMATION

Member Name (Last, First, Middle)			NDPERS Member ID
Last Four Digits of Social Security Number			Date of Birth
Spouse Name (Last, First, Middle)			
Address	City	State	Zip Code
Daytime Telephone Number		Date of Retirement	

PART B LEVEL OF COVERAGE

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

☐ **I DO NOT** want health insurance at this time
☐ Single Coverage (Self Only)
☐ Family Coverage (Self and other eligible family members)

Change Reason

☐ New Coverage
☐ Loss of Other Coverage
☐ Transfer from existing policy
☐ Remove Dependent
☐ Add Dependent: Is this an adult child? ☐No ☐Yes. Please answer the following questions.
Is adult child married? ☐No ☐Yes
Is adult child eligible to enroll under their own or spouse's employer insurance plan? ☐No ☐Yes
Is adult child Disabled? ☐No ☐Yes

PART C DEPENDENT INFORMATION

1. List all family members to be covered under the plan, 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

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	Marital Status	Social Security Number
	Spouse				

PART D PAYMENT METHOD

RETIREMENT GROUP	PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS ☐ TFFR ☐ Job Service ☐ TIAA-CREF ☐ NDPERS Defined Contribution ☐ Ex-Legislator ☐ Alternate Retirement System	☐ Deduct from pension check (Option only available for NDPERS/NDHPRS, TFFR, Job Service) ☐ Withhold from bank account (Complete SFN 50134)

NOTICE TO MEMBER

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

If you or any eligible dependents have both Part A and Part B this form is not applicable. You must complete a "Retiree Health Insurance with Medicare Application SFN 59562" and a "Medicare Blue Rx Prescription Drug Plan Group Enrollment Form". You can obtain these forms on the NDPERS website or by calling NDPERS at 328-3900 or 1-800-803-7377.

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

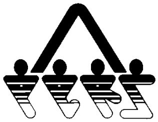
If you are drawing a pension from TIAA-CREF or the NDPERS Defined Contribution Plan or you are an ex-legislator, your health insurance premiums must be withheld from a bank account.

PART E MEMBER AUTHORIZATION

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

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

Signature of Applicant	Date Signed



RETIREE HEALTH INSURANCE WITH MEDICARE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 59562 (Rev. 06-2011)

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A MEMBER INFORMATION

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

Spouse Name (Last, First, Middle)

Address	City	Zip Code

Date of Retirement

PART B LEVEL OF COVERAGE

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

☐ I **DO NOT** want health insurance at this time
☐ Single Coverage (Self Only)
☐ Family Coverage (Self and other eligible family members)

Change Reason

☐ New Coverage
☐ Loss of Other Coverage
☐ Transfer from existing policy
☐ Remove Dependent
☐ Add Dependent: Is this an adult child? ☐No ☐Yes. Please answer the following questions.
Is adult child married? ☐No ☐Yes
Is adult child eligible to enroll under their own or spouse's employer insurance plan? ☐No ☐Yes
Is adult child Disabled? ☐No ☐Yes

PART C DEPENDENT INFORMATION

1. List all family members to be covered under the plan, 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

Are you or spouse or any of your eligible dependents currently covered by Medicare due to ESRD? ☐No ☐Yes

Last Name First Name Middle Name	Date of Birth	Gender	Relationship	Marital Status	Medicare Part A*	Medicare Part B*	Effective Date
(Spouse)			Spouse		☐ YES ☐ NO	☐ YES ☐ NO	
(Dependent)					☐ YES ☐ NO	☐ YES ☐ NO	
(Dependent)					☐ YES ☐ NO	☐ YES ☐ NO	

NOTICE TO MEMBER (Please refer to the "Dakota Plan & Dakota Retiree Plan" information)

***If you checked YES, you MUST submit a photocopy of the applicable Medicare ID card(s) and complete the MedicareBlue Rx Prescription Drug Plan Group Enrollment Form.** In order to continue or obtain coverage under the Dakota Plan or Dakota Retiree Plan, any Medicare Eligible member MUST carry both Parts A & B of Medicare to remain eligible for our health plan. Therefore, to remain on our plan or obtain new coverage, any eligible Medicare member should not defer Part B of Medicare when he/she becomes eligible for it. The Medicare Blue Rx Prescription Drug Plan Group Enrollment Form maybe obtained on our website at www.nd.gov/ndpers or by calling NDPERS at 328-3900 or 1-800-803-7377.

Any eligible Medicare member must provide proof of enrollment by submitting a photocopy of the applicable Medicare ID card.

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

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

PART D PAYMENT METHOD

RETIREMENT GROUP			PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS	☐ TFFR	☐ Job Service	☐ Deduct from pension check (Option only available for NDPERS/NDHPRS, TFFR, Job Service)
☐ TIAA-CREF	☐ NDPERS Defined Contribution		☐ Withhold from bank account (Complete SFN 50134)
☐ Ex-Legislator	☐ Alternate Retirement System		

PART E MEMBER AUTHORIZATION

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

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

______________________________ Signature of Applicant

______________________________ Date Signed

2012 Group Participant Enrollment Form

S5743_080211_GB02 RE

Group MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

2012 GROUP PARTICIPANT ENROLLMENT FORM

INSTRUCTIONS: Please complete all sections of this form. Please read each statement in Section F. Sign and date where indicated in Section D. Return this enrollment form to your employer, union group administrator or other designated contact.

A. PERSONAL INFORMATION (Please Print Clearly):

Group Name:		Group Number:	**Requested Effective Date:**
Last Name:	First Name:	Middle Initial:	❑ Mr. ❑ Mrs. ❑ Ms.
Birth Date: (mm/dd/yyyy) ____/____/____	❑ Male ❑ Female	Home Phone Number: ( ) –	Alternate Phone Number (optional): ( ) –

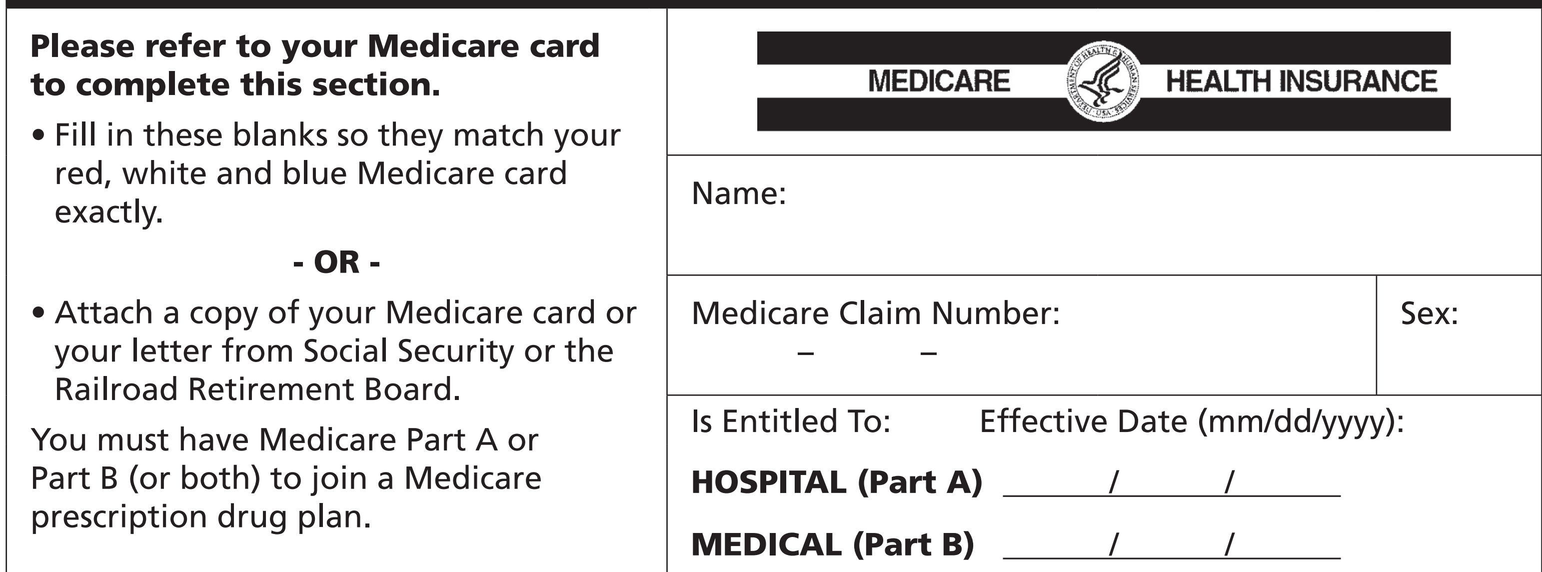
Permanent Residence Street Address **(no P.O. Box number)**:

City: State: ZIP Code:

Mailing Street Address (only if different from your Permanent Residence Street Address):

City: State: ZIP Code:

B. PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:



Please refer to your Medicare card to complete this section.

- Fill in these blanks so they match your red, white and blue Medicare card exactly.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

Name:

Medicare Claim Number: – –

Sex:

Is Entitled To: Effective Date (mm/dd/yyyy):

HOSPITAL (Part A) ____/____/____

MEDICAL (Part B) ____/____/____

Distribution: White Copy: Carrier Yellow Copy: Enrollee

C. PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP MEDICARE COORDINATE YOUR BENEFITS:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to Group MedicareBlue Rx (PDP)?
   ❑ Yes ❑ No
   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: ________ ID number for this coverage: ________ Group number for this coverage: ________

2. Are you a resident in a long-term care facility, such as a nursing home? ❑ Yes ❑ No
   If yes, please provide the following information:
   Name of the Institution: ________________
   Address and Phone Number of Institution (number and street):
   ____

If you have special needs, alternative formats are available. Please contact Group MedicareBlue Rx Customer Service at **1-877-838-3827**, 8 a.m. to 8 p.m., daily, Central and Mountain Times. TTY users should call **711**.

D. PLEASE READ SECTIONS E AND F AND SIGN BELOW:

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application, including the information in Sections E and F. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Group MedicareBlue Rx or by Medicare.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Your Signature: ________________ **Today's Date:** ________

If you are the **authorized representative,** you **MUST** sign above and provide the following information:

Name (Print): ________________ Phone number: (_____)________

Address: ________________ City: ________ State: _____ ZIP Code: ________

Relationship to Enrollee: ________________

❑ I want all mail for this member sent to me.

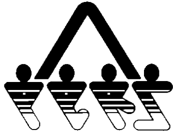
E. STOP – PLEASE READ THIS IMPORTANT INFORMATION – STOP

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Group MedicareBlue Rx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

F. ENROLLMENT AUTHORIZATION: By completing this enrollment application, I agree to the following:

After carefully reading all statements in this section, please sign Section D of this form. Keep the copy marked “Enrollee” for your records.

1. I understand Group MedicareBlue Rx is a Medicare-approved Part D sponsor. Coverage is available to members of an employer or union group and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota,* and Blue Cross Blue Shield of Wyoming.*
   *Independent licensees of the Blue Cross and Blue Shield Association
2. I understand Group MedicareBlue Rx is a Medicare prescription drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Group MedicareBlue Rx of any prescription drug coverage that I have or may get in the future. I can be in only one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Group MedicareBlue Rx will end that enrollment.
3. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year, or under certain special circumstances.
4. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Group MedicareBlue Rx network pharmacies.
5. I understand that once I am a member of Group MedicareBlue Rx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Group MedicareBlue Rx when I get it to know which rules I must follow to get coverage.
6. I understand that if I leave this plan and don’t have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare’s), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
7. I understand that benefits, premiums and cost-sharing are subject to change during the employer group’s renewal period.
8. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with one of the independent Blue Cross and Blue Shield plans offering Group MedicareBlue Rx, he/she may be paid based on my enrollment in Group MedicareBlue Rx.
9. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
10. I understand that if I obtain prescriptions outside the Group MedicareBlue Rx network, I may be required to pay any difference between the billed and allowed amount.
11. **Release of Information:** By joining this Medicare Prescription Drug Plan, I acknowledge that Group MedicareBlue Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations, and as otherwise permitted by law. I also acknowledge that Group MedicareBlue Rx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.



RETIREE LIFE INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53622 (Rev. 10-2011)

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3902

PART A MEMBER INFORMATION

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

PART B NDPERS GROUP LIFE INSURANCE

Effective Date:

☐ I elect **NOT** to Continue my Group Life Insurance

☐ I elect **To** continue my Group Life Insurance: (Check appropriate coverages below)

- ☐Basic Life
- ☐Supplemental Life: ☐At Current Level of Coverage ☐At a Reduced Level of Coverage: $_______________.00
- ☐Dependent Life: ☐At Current Level of Coverage ☐At a Reduced Level of Coverage: $_______________.00
- ☐Spouse Supplemental Life: ☐At Current Level of Coverage ☐At a Reduced Level of Coverage: $_______________.00

☐ Beneficiary (ies) Update

PART C PAYMENT METHOD

RETIREMENT GROUP		PAYMENT OPTION (must select one)
☐NDPERS/NDHPRS ☐TFFR ☐JOB SERVICE	→	☐ Deduct from my Pension Check ☐ Withhold from bank account (MUST Complete SFN 50134)
☐NDPERS DEFINED CONTRIBUTION ☐TIAA-CREF ☐EX - LEGISLATOR	→	☐ Withhold from bank account (MUST Complete SFN 50134)

PART D DESIGNATION OF BENEFICIARY

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.

PRIMARY BENEFICIARY(IES)

Name	Relationship	Social Security Number	Birth Date	% Share must = 100%	Address

CONTINGENT BENEFICIARY(IES)

Name	Relationship	Social Security Number	Birth Date	% Share must = 100%	Address

PART E MEMBER AUTHORIZATION

I authorize all physicians and other medical professional, hospitals, and other medical care institution, insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators to provide ING Employee Benefits and any benefit plan administrator, consumer reporting agencies, attorneys and independent claim administrators action on ING Employee Benefits behalf with information concerning medical care, advice, treatment or supplies provide the patient including information on mental illness and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.

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

______________________________ Signature of Applicant

______________________________ Date Signed

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Part A Member Information

For member identification, please provide all requested information.

Part B NDPERS Group Life Insurance

Indicate the effective date of your election.

Check the appropriate box(es) to elect the levels of coverage you had as an active employee and wish to continue. You must continue the basic life to continue the employee supplemental, the employee supplemental to continue dependent life, and the dependent life to continue 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 as an active employee or elect to decrease your level of coverage. NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part C Payment Method

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

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

Part D Designation of Beneficiary

Use full legal name. (Example: "Anna May Smith," not Mrs. John Smith")

A member may designate contingent beneficiary (ies) who will receive benefits if the primary beneficiary (ies) predecease member**.**

If you have more that two designated beneficiaries in either the primary or contingent beneficiary sections, please submit a typed attachment and include your name, NDPERS Member ID, last four digits of your social security number, date of birth, signature, and date.

If more than one person in a class (primary or contingent beneficiary) is named, they will share equally in the benefit unless specific shares are designated. If specific shares are designated, they must equal 100 percent. The benefit will be distributed as directed by the designation. If a named beneficiary does not survive, the share will be distributed among any surviving beneficiaries in proportion to the shares designated. **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.

Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established.

ESTATE DESIGNATION

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 E Member Authorization

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

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	Reason for termination
❐ Employee Basic Amount .... $ ________ Supplemental/Voluntary amount . $ ________ Other .... $ ________ **Total amount eligible for conversion $** ________	❐ Termination of employment ❐ Termination of group policy ❐ Reduction of coverage ❐ Retirement ❐ Loss of Dependent Status ❐ Disabled ❐ Death of Employee Spouse name ________
❐ Dependent spouse Basic Amount .... $ ________ Supplemental/Voluntary amount . $ ________ Other .... $ ________ **Total amount eligible for conversion $** ________	❐ Other (specify) ________
❐ 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

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).

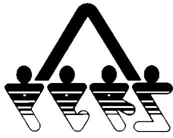
Example of Calculating Premium

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



RETIREE VISION/DENTAL INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53504 (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 MEMBER INDENTIFICATION

Name (Last, First, MI)	NDPERS Member ID
Last 4 Digits of Social Security Number	Date of Birth

PART B INSURANCE ELECTION

Change Effective Date	Plan ☐ Vision ☐ Dental

☐ Continuation of Coverage (COBRA) ☐ New Coverage – Date of 1st Check ____/_____/_____ ☐ Cancel Coverage ☐ Loss of COBRA Coverage
☐ Loss of Other Employer Coverage ☐ Surviving Spouse- Transferring from Contract # __________________ ☐ Surviving Spouse – New Coverage
☐ Medicare Eligible ☐ Add Dependent ☐ Delete Dependent ☐ Marriage ☐ Divorce

PART C ELECT COVERAGE

☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Child(ren) ☐ Retiree + Family

For Spouse and Dependent Coverage, Provide all information requested below:

Name (Last, First, Middle)	Relationship	Date of Birth	Sex	Marital Status*	Child Status**	Add	Drop

** For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, or Legally Separated.*
*** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.*

Other Coverage Information (Complete if you and /or any dependent have coverage with another insurer or carrier.)

Retiree/Dependent Name (Last, First, MI)	Name and Address of Other Insurer/Carrier	Policy/Plan Number	Effective Date	Other Coverage Type
				☐Single ☐Family
				☐Single ☐Family

PART D PAYMENT METHOD

RETIREMENT GROUP	PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE →	☐ Deduct from pension check ☐ Withhold from bank account (Complete SFN 50134)
☐ TIAA-CREF ☐ NDPERS DEFINED CONTRIBUTION ☐ EX-LEGISLATOR →	☐ Withhold from bank account (Complete SFN 50134)

PART E WAIVE COVERAGE

IF YOU DO NOT WANT COVERAGE - COMPLETE THIS WAIVER SECTION.

I have been given the opportunity to apply for Group Insurance offered by NDPERS and have decided not to accept the offer for:
(check all that apply) ☐ myself ☐ spouse only ☐ child(ren) only ☐ myself and entire family
because: ☐ I have other coverage through my spouse's employer ☐ I have other individual coverage ☐ Other ___________________
Should I desire to apply for insurance in the future, I realize that a "late entrant" penalty may be applied.

PART F MEMBER AUTHORIZATION

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.

I have read this application in its entirety **(including the back page)** and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans insured based on this application.

______________________________ Member Signature

______________________________ Date of Signature

Please refer to the "Retiree Coverage" plan information

Part A Member Identification

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

Part B Insurance Election

Indicate change effective, insurance plan the change applies, and the appropriate "qualifying event".

Part C Elect Coverage

Select the level of coverage. If electing Retiree + Spouse, Retiree + Child(ren), or Retiree + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

Indicate if you and/or any dependent have other coverage.

Part D Payment Method

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

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

Part E Waiver of Coverage

If you do not wish to enroll in the plan, complete Parts A, E and F.

Part F Member Authorization

You must sign and date this section for the 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.

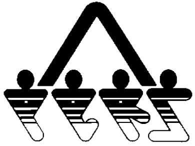
Your Premium: $______________ ***(Transfer the premium amount from the calculation on the rate sheet)***

______________________	__ __/__ __/__ __ __ __	______________________	__ __/__ __/__ __ __ __
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.

Voluntary



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