



RETIREE GROUP HEALTH INSURANCE APPLICATION
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
 SFN 16277 (Rev. 01-03)

Health Insurance Coverage Underwritten
 **Blue Cross Blue Shield**
 of North Dakota 4510 13th Ave SW
 Fargo, ND 58121

[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

Member Name (Last, First, Mi)		Date of Retirement	<input type="checkbox"/> Single
			<input type="checkbox"/> Married
Social Security Number	Date of Birth	Sex	
Spouse Name (Last, First, Mi)			
Social Security Number	Date of Birth	Sex	
Address	Daytime Telephone Number		
City	State	Zip Code + 4	

PART B TYPE OF COVERAGE REQUESTED

I do not want health insurance at this time
 Self Only
 Family Plan; **For family coverage, provide information below on all current dependents, listing spouse first.**

Last Name	First Name	Date of Birth	Sex	Relationship

PART C MEDICARE INFORMATION

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.

If YES, you MUST submit a photocopy of the applicable Medicare ID card/s

Effective Date	Medicare ID #
Do you have Medicare Part A? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Do you have Medicare Part B? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Does your spouse have Medicare Part A? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Does your spouse have Medicare Part B? <input type="checkbox"/> YES <input type="checkbox"/> NO	

PART D PAYMENT METHOD & MEMBER AUTHORIZATION

<p>RETIREMENT GROUP</p> <input type="checkbox"/> NDPERS/NDHPRS <input type="checkbox"/> TFFR <input type="checkbox"/> JOB SERVICE → <p>.....</p> <input type="checkbox"/> TIAA-CREF <input type="checkbox"/> NDPERS DEFINED CONTRIBUTION → <input type="checkbox"/> EX-LEGISLATOR	<p>PAYMENT OPTION – MUST SELECT ONE</p> <input type="checkbox"/> Deduct from pension check <input type="checkbox"/> Withhold from bank account (Complete SFN 50134) <p>.....</p> <input type="checkbox"/> Withhold from bank account (Complete SFN 50134)
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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

PART E NDPERS USE ONLY

Group Number	Effective date of coverage:	Effective date of change:
<input type="checkbox"/> Retirement <input type="checkbox"/> New Coverage <input type="checkbox"/> Medicare Update <input type="checkbox"/> Disability <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Transfer from NDPERS Contract No. _____	<p>Change in Dependents</p> <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Remove Dependent(s)	<p>Change in Marital Status</p> <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Please refer to the “Dakota Plan & Dakota Retiree Plan” sheets.

Part A Member Information

Enter your name, date of retirement, marital status, social security number, date of birth, and sex.

Enter your spouse’s name, social security number, date of birth, and sex.

Enter your mailing address and day time telephone number.

Part B Type of Coverage Requested

Check the appropriate level coverage.

If you do not want health coverage, mark the appropriate box and skip to “Signature of Applicant” in Part D--Sign and date.

If selecting family coverage, list all covered dependents.

Part C Medicare Information

Our health insurance subscribers MUST have both Part A and Part 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.

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

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 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.

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