



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 IDENTIFICATION	
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 <input type="checkbox"/> Vision <input type="checkbox"/> Dental
<input type="checkbox"/> Continuation of Coverage (COBRA) <input type="checkbox"/> New Coverage – Date of 1 st Check ____/____/____ <input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Loss of COBRA Coverage <input type="checkbox"/> Loss of Other Employer Coverage <input type="checkbox"/> Surviving Spouse- Transferring from Contract # _____ <input type="checkbox"/> Surviving Spouse – New Coverage <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce	

PART C ELECT COVERAGE							
<input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree + Spouse <input type="checkbox"/> Retiree + Child(ren) <input type="checkbox"/> 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
				<input type="checkbox"/> Single <input type="checkbox"/> Family
				<input type="checkbox"/> Single <input type="checkbox"/> Family

PART D PAYMENT METHOD	
<input type="checkbox"/> NDPERS/NDHPRS <input type="checkbox"/> TFFR <input type="checkbox"/> JOB SERVICE → <input type="checkbox"/> TIAA-CREF <input type="checkbox"/> NDPERS DEFINED CONTRIBUTION → <input type="checkbox"/> EX-LEGISLATOR	PAYMENT OPTION – MUST SELECT ONE <input type="checkbox"/> Deduct from pension check <input type="checkbox"/> Withhold from bank account (Complete SFN 50134) <input type="checkbox"/> 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) <input type="checkbox"/> myself <input type="checkbox"/> spouse only <input type="checkbox"/> child(ren) only <input type="checkbox"/> myself and entire family because: <input type="checkbox"/> I have other coverage through my spouse's employer <input type="checkbox"/> I have other individual coverage <input type="checkbox"/> 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.
<div style="display: flex; justify-content: space-between;"> <div>_____</div> <div>_____</div> </div> <div style="display: flex; justify-content: space-between;"> <div>Member Signature</div> <div>Date of Signature</div> </div>

Please refer to the "Retiree Coverage" plan information

Part A Member Identification

Enter your name, NDPERS member id, last four 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.