



RETIREE VISION INSURANCE ENROLLMENT/CHANGE
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
 SFN 53505 (REV. 07-2007)



Policy Number: #G010-350308

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, Mi)				Social Security Number			
Mailing Address				City	State	Zip Code + 4	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Daytime Telephone Number		
PART B ENROLLMENT/CHANGE							
<input type="checkbox"/> Continuation of Coverage <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"/> Remove Dependent <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Address Change							
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, Mi)		Relationship	Date of Birth	Sex	Marital Status*	Child Status**	Add Drop
<small>* 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.</small>							
Other Vision Coverage Information (Complete if you and /or any dependent have vision coverage with another insurer or carrier.)							
Retiree/Dependent Name (Last, First, Mi)		Name and Address of Other Vision Insurer/Carrier		Policy/Plan Number	Effective Date	Other Vision Coverage Type	
						<input type="checkbox"/> Single <input type="checkbox"/> Family	
						<input type="checkbox"/> Single <input type="checkbox"/> Family	
PART D PAYMENT METHOD							
RETIREMENT GROUP				PAYMENT OPTION – MUST SELECT ONE			
<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				<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 Vision 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 vision 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 vision 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			
PART G NDPERS USE ONLY							
Group Number		Effective date of coverage:			Effective date of change:		

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Please refer to the "Retiree Vision Coverage" sheet for plan information.

Part A Member Information

Enter your name, social security number, mailing address, date of birth, gender, marital status, and day time telephone number.

Part B Enrollment/Change

Check 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 vision 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 dental 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 vision plan, complete Parts A, E, and F.

Part F Member Authorization

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

Part G NDPERS Use Only