

**EMPLOYER VERIFICATION OF INSURANCE COVERAGE**

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53621 (Rev. 12-2009)

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

Instructions: Please complete Part A information and forward the form to your former employer to verify coverage in Parts B, C, D, and to sign Part E. These Parts must be completed by an authorized staff employee of the employer. This information is used to determine eligibility for insurance provided through the North Dakota Public Employees Retirement System (NDPERS). This information must be returned to NDPERS accompanied by the applicable enrollment form(s).

PART A EMPLOYEE AND EMPLOYER INFORMATION	
Employee Name (Last, First, Middle)	NDPERS Member ID (If applicable)
Last Four Digits of Social Security Number	
Organization Name	NDPERS Organization ID (If applicable)
Date Employment Terminated	
PART B HEALTH INFORMATION	
Last Month and Year the Employee is Covered on Employer Group Insurance Billing: ____/____	
Does employee currently participate in the employer sponsored HEALTH plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, Current level of coverage: _____	
Has employee been covered under COBRA? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, Beginning date of COBRA: ____/____/____ Ending date of Health Coverage: ____/____/____	
PART C DENTAL INFORMATION	
Last Month and Year the Employee is Covered on Employer Group Insurance Billing: ____/____	
Does employee currently participate in the employer sponsored DENTAL plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, Current level of coverage: _____	
Has employee been covered under COBRA? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, Beginning date of COBRA: ____/____/____ Ending date of Dental Coverage: ____/____/____	
PART D VISION INSURANCE	
Last Month and Year the Employee is Covered on Employer Group Insurance Billing: ____/____	
Does employee currently participate in the employer sponsored VISION plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, Current level of coverage: _____	
Has employee been covered under COBRA? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, Beginning date of COBRA: ____/____/____ Ending date of Vision Coverage: ____/____/____	
PART E EMPLOYER CERTIFICATION	
Signature of Authorized Personnel	Date of Signature
Telephone Number:	