


**RETIREE CONTINUATION OF GROUP DENTAL COVERAGE (COBRA)**

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53800 (REV. 01-2006)

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**

<b>PART A MEMBER INFORMATION</b>		
Name (Last, First, MI)	Social Security Number	
<b>PART B NDPERS GROUP INSURANCE ONLY</b>		
Do you wish to continue your current coverage in the NDPERS <u>Dental</u> Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Current Level of Coverage: <input type="checkbox"/> Self Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Family		
<input type="checkbox"/> Reduced Level of Coverage (Self Only) ( <b>SFN 53504 MUST accompany this form</b> )		
Employees terminating employment, or otherwise losing eligibility, may continue their NDPERS Group Dental Coverage at their own expense for a maximum of 18 months subject to the following:		
<ol style="list-style-type: none"> <li>1. You must be a member of the plan at time of loss of eligibility.</li> <li>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.</li> <li>3. You must complete and submit this election form to NDPERS within 60 days from your last date of coverage.</li> </ol>		
If you do not choose continuation coverage, your group dental coverage will end on the last day of the month for which premiums were paid.		
<b>PART C PAYMENT METHOD &amp; MEMBER AUTHORIZATION</b>		
(If a payment method is not elected, you must submit your personal check for the monthly premium to NDPERS by the 1 <sup>st</sup> day of each month. NDPERS will not send you monthly premium notices. Failure to remit your premium by the due date will result in loss of dental coverage.)		
<p align="center"><b><u>RETIREMENT GROUP</u></b></p> <input type="checkbox"/> NDPERS/NDHPRS <input type="checkbox"/> TFFR <input type="checkbox"/> JOB SERVICE    →	<p align="center"><b><u>PAYMENT OPTION – MUST SELECT ONE</u></b></p> <input type="checkbox"/> Deduct from pension check <input type="checkbox"/> Withhold from bank account (Complete <a href="#">SFN 50134</a> )	
<input type="checkbox"/> TIAA-CREF <input type="checkbox"/> NDPERS DEFINED CONTRIBUTION → <input type="checkbox"/> EX-LEGISLATOR	<input type="checkbox"/> Withhold from bank account (Complete <a href="#">SFN 50134</a> )	
I have read this application in its entirety ( <b>including the back page</b> ) 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.		
<hr style="width: 100%;"/> Signature of Member		<hr style="width: 100%;"/> Date Signed
<b>PART D NDPERS USE ONLY</b>		
Group Number	Month the last dental insurance premium will be paid:	Effective date of coverage:

**ORIGINAL TO NDPERS – PLEASE MAKE A PHOTOCOPY FOR YOUR RECORDS**