



**DEPENDENT CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)**  
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
SFN 53883 (06/07)

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 COBRA MEMBER INFORMATION (Spouse or Dependents Losing Coverage)</b>   |   |   |  |                            |
| Name (Last, First, MI)  |   |   | Social Security Number   |                            |
| Date of Birth   | Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female |   | Home Telephone Number  |                            |
| Address   |   | City  | State  | Zip + 4                    |
| <b>PART B TRANSFERRING FROM POLICY HOLDER</b>   |   |   |  |                            |
| Name (Last, First, MI)  |   |   | Social Security Number   |                            |
| <b>PART C QUALIFYING COBRA EVENT</b>  |   |   |  |                            |
| <input type="checkbox"/> Age 23, no longer full-time student and financially dependent  |   |   | <input type="checkbox"/> Age 26 <input type="checkbox"/> Married |                            |
| <input type="checkbox"/> Divorce from current contract holder   |   | <input type="checkbox"/> Termination of current contract holder |  |                            |
| <input type="checkbox"/> Death of current contract holder   |   | <input type="checkbox"/> Contract holder entitled to Medicare   |  |                            |
| Date of Event:  |   |   |  |                            |
| <b>PART D DEPENDENT ELECTION</b>  |   |   |  |                            |
| Do you wish to continue your current coverage in the NDPERS Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  | Effective Date (Mo/Yr)     |
| If Yes, at what Level of Coverage: <input type="checkbox"/> Self Only <input type="checkbox"/> Self & Child(ren)  |   |   |  |                            |
| List all family members to be covered below.  |   |   |  |                            |
| <i>Name</i>   | <i>Relationship</i>   | <i>Gender</i>   | <i>Date of Birth</i>   | <i>Social Security No.</i> |
|   |   |   |  |                            |
|   |   |   |  |                            |
| <b>PART E DEPENDENT AUTHORIZATION</b>   |   |   |  |                            |
| Dependents losing eligibility may continue the NDPERS Group Health Coverage at their own expense for a maximum of 36 months.  |   |   |  |                            |
| <b>PAYMENT OF PREMIUM:</b><br>NDPERS will send you monthly premium notices. You have the following premium payment options.   |   |   |  |                            |
| 1. To have your monthly premium withheld from a bank account complete the Authorization for Automatic Premium Deduction (SFN 50134).  |   |   |  |                            |
| 2. You may submit your personal check for the monthly premium to NDPERS by the 15 <sup>th</sup> day of each month.<br><b>Failure to remit your premium by the due date will result in loss of coverage.</b>   |   |   |  |                            |
| I have read this application in its entirety <b>(including the COBRA notice on 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. |   |   |  |                            |
| _____   |   |   | _____  |                            |
| Dependent Signature   |   |   | Date   |                            |
| <b>PART F NDPERS USE ONLY</b>   |   |   |  |                            |
| Group Number  | Month the last health insurance premium will be paid:                   | Begin Date  | End Date   |                            |

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

On July 1, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group plans offer employees and their families the opportunity for a temporary extension of coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

If you are the spouse of an employee covered by the employer's group plan, you have the right to choose continuation coverage for yourself if you lose group coverage under the group plan for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for the reasons other than gross misconduct) or reduction in your spouse's hours of employment with the employer.
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to (that is, covered by) Medicare.

In the case of a dependent child of an employee covered by the employer's group plan, he or she has the right to continuation coverage if group Health coverage under the group plan is lost for any of the following reasons:

1. The death of the contract holder;
2. A termination of the contract holder's employment (for reasons other than a gross misconduct) or reduction in the contract holder's hours of employment with the employer;
3. The contract holder's divorce or legal separation;
4. The contract holder becomes entitled to (that is, covered by) Medicare;
5. The dependent child ceases to be a "dependent child" under the group plan.

Under the law, the employee or a family member has the responsibility to inform NDPERS of a divorce, legal separation or a child losing dependent status under the group plan within 60 days of the date of the event. The employer with whom you have your NDPERS group benefit plan has the responsibility to notify NDPERS of an employee's death, termination, and reduction in hours of employment or Medicare entitlement.

Once is notified that one of these events has happened, you will in turn be notified that you have the right to choose continuation coverage. Under the law you have at least 60 days from the date you would lose coverage because of one of the events described above to inform NDPERS that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group insurance coverage will end. Not choosing continuation coverage may cause a break in your continued coverage and such break of more than sixty-three days may cause loss in coverage portability.

If you choose continuation of coverage, NDPERS is required to give you coverage, which, as of the time coverage is being provided is identical to the coverage provided under the group health plan to similarly situated employees or family members.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may extend to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social security disability purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, you must notify NDPERS of the determination within 60-days of receipt of the Social Security Determination Notice AND before the end of the original 18-month period. The affected individual must also notify NDPERS within 30 days of any final determination that the individual is no longer disabled.

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The employer no longer provides group coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become entitled to (that is, covered by) Medicare; or
4. You extend coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.