

PART D OTHER COVERAGE INFORMATION

Are you, your spouse or any of your Eligible Dependents currently or were previously covered by another insurance benefit plan(s), **INCLUDING NDPERS BENEFIT PLAN(S)**? No, skip to next section Yes, **please complete this section AND attach Certificate(s) of Coverage or other documentation from your insurance company. Failure to provide documentation may affect your waiting period.**

Plan**	Other Coverage Name & Phone Number	Policy Number	Policyholder (last, first, middle)	Date of Birth	Policy Coverage Dates (mm-dd-yy)	Name(s) of Person(s) Covered
					From: To:	
					From: To:	

****For Plan, indicate type of coverage -- Dental, or Vision**

Do you intend to keep your current policy(ies) in force after the effective date of this Application?

Yes No, Why? _____

Workers' Compensation/No-Fault

Are you, your spouse or any of your Eligible Dependents currently receiving or have received worker's compensation benefits? No Yes
 Are you, your spouse or any of your Eligible Dependents currently receiving no-fault benefits? No Yes

Person's Name	Injury Date (MM-DD-YY)	Type of Injury	Company Providing Benefits & Phone Number

PART E MEMBER AUTHORIZATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (front and back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively cancelling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

- I understand members are subject to limitations and exclusions outlined in the relevant Benefit Plan/Policy.
- I understand that in the event the group through which I am enrolled elects to terminate, the Insurance Carrier has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.
- I understand conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with the Insurance Carrier and has enrolled as a group with another Insurance Carrier.
- I understand, in the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit to NDPERS.
- I acknowledge that the Summary of Benefits and coverage and other related plan information is available on the NDPERS website at www.nd.gov/ndpers.

Please retain a copy of this Application for your records

 Member's Signature

 Date of Signature