



DENTAL/VISION INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58792 (Rev. 10-2012)

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

PART A MEMBER IDENTIFICATION			
Employee Name (Last, First, Middle)		NDPERS Member ID	
Last Four Digits of Social Security Number	Date of Birth	Daytime Telephone Number	
Organization Name		NDPERS Organization ID	
Date of Hire		Active in the Military? <input type="checkbox"/> No <input type="checkbox"/> Yes	

PART B INSURANCE ELECTION

Effective Date of Change (MM-DD-YYYY):

Section 1 Reason for Change:

<input type="checkbox"/> New Coverage (I do not have existing coverage)	<input type="checkbox"/> Loss of Other Coverage
<input type="checkbox"/> Annual Enrollment	<input type="checkbox"/> Transfer Employment:
<input type="checkbox"/> Cancel Dental Coverage	from _____ to _____
<input type="checkbox"/> Cancel Vision Coverage	<input type="checkbox"/> Transfer from existing policy (Complete Part D)
<input type="checkbox"/> Remove Dependent	
<input type="checkbox"/> Add Dependent: Is this an adult child? <input type="checkbox"/> No <input type="checkbox"/> Yes, <u>Please answer the following questions.</u>	
Is adult child married? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Is adult child Disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Section 2 Level Of Coverage for Plan(s):

<p>Dental Insurance</p> <input type="checkbox"/> Single Coverage <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee and Family	<p>Vision Insurance</p> <input type="checkbox"/> Single Coverage <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee and Family
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PART C DEPENDENT INFORMATION

1. List all family members to be covered under the plan indicated in Part B, Section 2, other than yourself.

- Indicate dependent's address below name if address is different from yours.
- For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
- For Marital Status, enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed

2. If your marital status is single and you are applying for family coverage, you are required to attach a copy of the state birth certificate for each Eligible Dependent unless previously submitted.

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. Section 3402. The individual's social security number will be used for tax reporting and as an identification number.

Dependent Name (last, first, middle) If address is different then subscriber, indicate address under name	Relationship	Gender	Date of Birth	Social Security Number	Marital Status	Court Ordered Coverage	Active Military
	Spouse					N/A	<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
						<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

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.

Please retain a copy of this Application for your records

 Member's Signature

 Date of Signature