

**NOTICE OF TRANSFER**

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
SFN 53706 (Rev. 06-2015)

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, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
<b>PART B CURRENT EMPLOYER</b>	
Organization Name	NDPERS Organization ID
Last Date of Service with Current Agency	Date of Last Regular Paycheck
Last Month Insurance Premium(s) will be paid by your agency/or this employee (Month & Year) :	Projected Accumulated hours of sick leave to date of transfer:
<b>PART C CURRENT PLAN INFORMATION</b> (Check yes or no for all NDPERS plans the employee is currently participating in)	
Defined Benefit Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes
Defined Contribution Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes
Deferred Compensation (457)	<input type="checkbox"/> No <input type="checkbox"/> Yes, Provider(s): _____ Monthly Deduction: \$ _____ (if more than one provider- attach a detailed memo)
Group Health Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes, <input type="checkbox"/> Single <input type="checkbox"/> Family
Group Life Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes, <input type="checkbox"/> \$3,500 Basic Life <input type="checkbox"/> Supplemental \$ _____ .00 <input type="checkbox"/> Dependent \$ _____ .00 <input type="checkbox"/> Spouse Supplemental \$ _____ .00
Group Dental Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes, <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Individual & Child(ren) <input type="checkbox"/> Family
Group Vision Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes, <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Individual & Child(ren) <input type="checkbox"/> Family
Long Term Care Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes, Premiums: \$ _____ Employee \$ _____ Spouse
FlexComp Plan	<input type="checkbox"/> No <input type="checkbox"/> Yes, <input type="checkbox"/> Medical Spending, \$ _____ Annual Deduction <input type="checkbox"/> Dependent Care, \$ _____ Annual Deduction
<b>PART D AUTHORIZATION OF CURRENT AUTHORIZED AGENT</b>	
I certify that the above information is true and correct.	
_____	_____
Authorized Agent Signature	Telephone Number
_____	_____
Date of Signature	
<b>PART E NEW EMPLOYER</b>	
Organization Name	NDPERS Organization ID
First Day of Service with New Agency:	Date of First Regular Paycheck
<u>New Job Classification:</u> <input type="checkbox"/> Classified State <input type="checkbox"/> Non-Classified State <input type="checkbox"/> Non-State <input type="checkbox"/> State University System <input type="checkbox"/> TIAA-CREF <input type="checkbox"/> Judge <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Elected Official <input type="checkbox"/> Appointed Official <input type="checkbox"/> ND TFFR	
<u>Employment Type:</u> <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	
<u>Status:</u> <input type="checkbox"/> Contributing <input type="checkbox"/> Non-Contributing	
<u>Seasonal:</u> <input type="checkbox"/> 6 Months <input type="checkbox"/> 9 Months <input type="checkbox"/> 10 Months <input type="checkbox"/> 11 Months	
<b>PART F AUTHORIZATION OF NEW AUTHORIZED AGENT</b>	
I certify that the above information is true and correct.	
_____	_____
Authorized Agent Signature	Telephone Number
_____	_____
Date of Signature	

## INSTRUCTIONS

Often employees will terminate their position with an employer participating in NDPERS and take a job with another employer who is also participating in NDPERS. Therefore, the employee's membership is transferred to the new employer and membership IS NOT terminated unless the new employer does not offer or is not eligible for a particular NDPERS plan.

### **Part A Member Information**

For member identification, please provide all requested information.

### **Part B Current Employer**

A NDPERS Transfer Kit must be given to the employee to complete. **A completed kit must accompany the Notice of Transfer SFN 53706.**

Indicate the current employer's name and department number. Indicate the last day of employment and the last regular paycheck issued to the employee.

Indicate last month insurance premiums will be paid by your agency/employee.

Indicate the projected accumulated unused sick leave at the date of transfer.

### **Part C Current Plan Information**

Check the appropriate box on the right side for all NDPERS plans. If the employee does not participate in a plan, check the NO box. If the employee does currently participate, check the YES box and complete all applicable boxes following, if any.

### **Part D Authorization of Authorized Agent**

The current agency's designated NDPERS authorized agent must sign and date this form.

### **Part E New Employer**

This form should be forwarded to the new employer. The new employer should indicate the organization name and NDPERS ID; as well as, the first day of employment and the employee's first regular paycheck.

The new employer should transfer any eligible plan participation as indicated in Part C with NO change in the levels of coverage.

Any plans the employee currently participates in but not offered or eligible through new employment will be terminated.

Any plans the employee currently does not participate in but now is offered or eligible through new employment, the employer must enroll as a new employee. See your NDPERS Employer's Guide for instructions for enrolling a new employee.

### **Part F Authorization of Authorized Agent**

The new agency's designated NDPERS authorized agent must sign and date this form.



## TRANSFER OF UNUSED SICK LEAVE VERIFICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
SFN 53404 (Rev. 01-2014)

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>	
Member Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
<b>PART B MEMBER AUTHORIZATION</b>	
<p>I authorize the exchange of unused sick leave information between my Former Employer, New Employer, and the North Dakota Public Employees Retirement System.</p> <p>I understand that a completed "Transfer of Unused Sick Leave Verification SFN 53404" MUST be on file at NDPERS within 60 days from the date I leave employment with my former employer.</p> <p>I understand that upon my termination of employment, I will have the opportunity to convert my unused sick leave to service credit according the North Dakota Administrative Code Chapter 71-02-03-06.</p>	
_____	_____
Member's Signature	Date of Signature
<b>PART C FORMER EMPLOYER VERIFICATION</b>	
Organization Name	NDPERS Organization ID
Total number of hours of unused sick leave at time of employment transfer:	Hours
Signature of Authorized Agent	Date of Signature
<b>PART D NEW EMPLOYER VERIFICATION</b>	
Organization Name	NDPERS Organization ID
Total number of hours of unused sick leave <b><u>accepted:</u></b>	Total number of hours of unused sick leave <b><u>rejected:</u></b>
Signature of Authorized Agent	Date of Signature



## **INSTRUCTIONS**

### **PART A - MEMBER INFORMATION**

For member identification, please provide all requested information.

### **PART B – MEMBER AUTHORIZATION**

Member must read authorization, provide signature and date. This will authorize the information to be exchanged between employers and NDPERS. Once signed, member should forward the form to their former employer for completion.

### **PART C – FORMER EMPLOYER VERIFICATION**

Member's former employer must complete all information requested in Part C for the section to be valid. Once completed, former employer should forward the form to the new employer for completion.

### **PART D – NEW EMPLOYER VERIFICATION**

Member's new employer must complete all information requested in Part D for the section to be valid. Once sections A-D are completed, the form should be forwarded to NDPERS for processing.



**Section 3 Level Of Coverage for Plan:**

Single Coverage (Self Only)  
 Family Coverage (Self and Spouse OR Self and Eligible Child(ren) OR Self, Spouse, Eligible Child(ren))

**PART C DEPENDENT INFORMATION**

1. List all family members to be covered under the plan indicated in Part B, Section 1, other than yourself.
  - a. Indicate dependent's address below name if address is different from yours.
  - b. For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
  - c. 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.
3. If you are adding a grandchild, a Grandchild Eligibility Verification SFN 60983 must be submitted also, along with a copy of the child's birth certificate.

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 MEDICARE COVERAGE INFORMATION**

Are you or spouse or any of your Eligible Dependents currently covered by Medicare?  
 No, skip to next section  Yes, complete the following:

Are you or spouse or any of your Eligible Dependents currently covered by Medicare due to End Stage Renal Disease?  
 No, skip to next section  Yes, complete the following:

Individual on Medicare (Last, First, Middle)	Medicare Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date

**PART E 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.**

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:	

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 F EMPLOYER CERTIFICATION OF ACA ELIGIBLE TEMPORARY EMPLOYEE**

I certify that this employee meets the definition of a full-time employee under the Affordable Care Act and as such, is being offered coverage. Check appropriate method of determination:

**Monthly Measurement**  
 **Date of New Hire:** \_\_\_\_/\_\_\_\_/\_\_\_\_  **Date of Change in Position/Increase in Hours:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Look-back Measurement**  
 The current measurement period used by the employer is: From:\_\_\_\_/\_\_\_\_ To:\_\_\_\_/\_\_\_\_  
 This information is required for NDPERS to determine enrollment eligibility.

\_\_\_\_\_ Date of Signature  
 \_\_\_\_\_ Authorized Agent's Signature

**PART G 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](http://www.nd.gov/ndpers).

**Please retain a copy of this Application for your records**

\_\_\_\_\_ Date of Signature  
 \_\_\_\_\_ Member's Signature



**PART A APPLICANT INFORMATION**

For applicant identification, please provide all requested information.

**PART B QUALIFYING COBRA EVENT**

- Check the box that describes the event that qualifies you for continuation coverage.
- Indicate the group insurance plan(s) you are electing for continuation coverage.
- Check the level of coverage. If you are not applying for the coverage, check the waive box.
- List all covered individuals. You may elect continuation coverage for only those family members that were covered on the plan at the time of the qualifying event.

**PART C PAYMENT METHOD**

If you check withhold from bank account, you must complete an Authorization for Automatic Premium Deduction SFN 50134. If a payment option is not elected, you will be billed for the premium due and will have 45 days from the date of this election to make your initial premium payment. Your continuation coverage will not be effective until the initial premium payment is received. NDPERS bills the 20<sup>th</sup> of each month for the following month's coverage. Your payment is due the 1<sup>st</sup> of the month. **Failure to remit your premium by the due date will result in loss of insurance coverage.**

**PART D APPLICANT AUTHORIZATION**

You must sign and date this form for it to be valid.

**ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS**



**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.

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- 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](http://www.nd.gov/ndpers).

**Please retain a copy of this Application for your records**

\_\_\_\_\_  
 Member's Signature

\_\_\_\_\_  
 Date of Signature

# LIFE CONVERSION INFORMATION REQUEST

ReliaStar Life Insurance Company, Minneapolis, MN  
A member of the Voya® family of companies  
PO Box 20, Minneapolis, MN 55440



## Instructions

**Employer/Plan Administrator:** This form should be completed and furnished to every person who has the conversion right.

**Employee/Member/Owner (person requesting information):** Complete the employee/member/spouse/children section and mail to the insurer at the address shown below within 31 days (see the certificate for applicable time period) of the date of termination of group coverage.

## TO BE COMPLETED BY EMPLOYER/PLAN ADMINISTRATOR

Group Policyholder/Plan Name \_\_\_\_\_ Policy Plan Number \_\_\_\_\_

Account Number \_\_\_\_\_ Group Situs \_\_\_\_\_

Employee/Member Name (Last, First, MI) \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN \_\_\_\_\_

Is employee/member disabled?  Yes  No If "Yes," give disability date. \_\_\_\_\_

Does policy have waiver provision?  Yes  No Was ownership assigned?  Yes  No

Initial Insurance Effective Date (with ReliaStar) \_\_\_\_\_ Employment Termination Date (if applicable) \_\_\_\_\_

Insurance Termination Date (DO NOT include grace period.) \_\_\_\_\_

## COVERAGE TERMINATING

	Basic Amount	Supplemental/Voluntary Amount	Other	Total Amount Eligible for Conversion
<input type="checkbox"/> Employee/Member	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Spouse	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Children (each)	\$ _____	\$ _____	\$ _____	\$ _____

Reason for termination:  Termination of employment  Termination of group policy  Reduction of coverage  Retirement

Loss of Spouse/Child Status  Death of Employee (list Spouse name) \_\_\_\_\_

Other (specify) \_\_\_\_\_

This form will be:  Handed  Mailed to Employee/Member/Owner (Date delivered or mailed.) \_\_\_\_\_

➔ Employer/Plan Administrator Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Company Phone (\_\_\_\_\_) \_\_\_\_\_

## TO BE COMPLETED BY EMPLOYEE/MEMBER/OWNER (Do not mail this form to insurer unless top portion is completed and signed by Employer/Plan Administrator.)

Requestor Name (Last, First, MI) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Relationship to Employee/Member \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

➔ Signature \_\_\_\_\_ Date \_\_\_\_\_

The Group Term Life Insurance coverages are terminating as indicated above. You may be eligible to convert existing coverage(s) to an individual life policy by mailing this form within 31 days (see the certificate for applicable time period) of such termination.

Please read the Conversion section/provision in the group certificate to determine eligibility. Complete this form and mail without delay. ReliaStar will send you a description of the conversion plan, premium rates and an application form.

**Important Notice:** This is not an application for conversion of group life coverage. Receipt of this form does not guarantee your eligibility to convert group coverage.

**IF YOU DO NOT RECEIVE INFORMATION WITHIN 21 DAYS AFTER THE DATE YOU MAILED THIS FORM, PLEASE CALL (800) 955-7736.**

Please mail to: Voya Employee Benefits, Group Conversions, Route 2-N, PO Box 20, Minneapolis, Minnesota 55440-0020

Do not enclose payment with this form. Send the entire form, when completed, to the above address.

**PREMIUM RATES FOR WHOLE LIFE CONVERSION POLICIES** (Rates are based on annual premium per \$1,000 of insurance.)

Age	Rate	Age	Rate	Age	Rate	Age	Rate
0	7.75	25	12.30	50	38.99	75	149.65
1	7.85	26	13.03	51	41.10	76	156.19
2	7.94	27	13.90	52	43.40	77	163.12
3	8.05	28	14.55	53	45.99	78	170.47
4	8.15	29	15.22	54	48.12	79	178.35
5	8.28	30	15.93	55	50.51	80	186.88
6	8.41	31	16.64	56	53.45	81	196.19
7	8.56	32	17.40	57	56.70	82	206.38
8	8.70	33	18.20	58	59.68	83	217.63
9	8.86	34	18.49	59	63.23	84	230.06
10	9.05	35	19.09	60	67.41	85	243.87
11	9.24	36	20.22	61	72.72	86	259.20
12	9.41	37	21.68	62	77.30	87	276.26
13	9.55	38	22.67	63	82.01	88	295.24
14	9.69	39	23.76	64	86.03	89	316.37
15	9.85	40	24.84	65	90.88	90	339.83
16	10.00	41	25.06	66	96.83	91	365.89
17	10.16	42	26.14	67	103.40	92	394.78
18	10.36	43	27.30	68	108.97	93	426.76
19	10.58	44	28.40	69	114.59	94	462.09
20	10.82	45	29.79	70	120.27	95	501.05
21	10.92	46	31.48	71	125.60	96	543.91
22	11.32	47	33.38	72	131.39	97	591.02
23	11.77	48	35.17	73	137.30	98	642.62
24	11.97	49	37.05	74	143.36	99	699.09

Issued by ReliaStar Life Insurance Company, policy form RL-WL2-POL-07 (may vary by state).

**Example of Calculating Premium**

Currently, you have \$25,000 of basic coverage under your group policy. Your current age is 35. When that term life insurance stops, you want to convert the entire amount. You want to be billed semi-annually.

Use the following steps to calculate the premium:

1. Determine the amount of coverage you wish to convert. **\$25,000**
2. Calculate the number of thousands you wish to convert by dividing the amount from step 1 by 1,000. **\$25,000/1,000 = 25**
3. Find the rate corresponding to your age at the time of conversion. **\$19.09**
4. Multiply the number of thousands from step 2 by the rate found in step 3. **25 \* 19.09 = \$477.25**
5. Find a policy fee corresponding to the amount of coverage you elected in step 1. **\$12.00**
6. Add the policy fee to the amount in step 4. **\$477.25 + 12.00 = \$489.25**
7. Multiply the amount in previous step by 0.265 for Quarterly billings, 0.515 for Semi-Annual billings, and 1 for Annual billings: **\$489.25 \* 0.515 = \$251.96**

**\$251.96 is your semi-annual premium amount, which you need to submit with the application.**

**Please note: Calculate premium separately for each proposed insured person, but submit one check.**

<b>ANNUAL POLICY FEES FOR WHOLE LIFE INSURANCE</b>	
<b>Converted Face Amount</b>	<b>Policy Fee Amount</b>
\$1,000 – \$500,000	\$12.00
\$500,001 - \$1,000,000	\$24.00
\$1,000,001 - \$1,500,000	\$36.00
\$1,500,001 - \$2,000,000	\$48.00



# Conversion of your Group Term Life Insurance Coverage

## What is conversion?

If you leave your job or your hours are reduced, you and your family may lose eligibility for group term life insurance coverage through your employer or association. Conversion allows you to convert life insurance coverage to an individual whole life policy when you or your family members are no longer eligible for group coverage.

## Why should I keep my life insurance coverage?

How would your loved ones be affected if you passed away and they were left without your financial resources? Would they be able to pay their everyday expenses or would they need to make sacrifices? Below are a few examples of how life insurance benefits could be used (coverage amounts may vary):

- Pay off any remaining medical bills, funeral costs and debts
- Provide ongoing financial support to your family
- Keep your family in your home by paying off the mortgage
- Fund your children's education

## What kind of conversion insurance plan is this?

It is referred to as an individual "non-participating" whole life insurance policy.<sup>1</sup> The individual whole life policy has a guaranteed cash value, which is a cash account that gradually builds as you pay premiums. You may be able to use this money at a later time for emergencies or temporary needs.

## Why should I convert my coverage?

- When you convert your coverage, you will lock in your premium payments when the new policy is issued – you will pay the same rate for life with no increases in premium due to age or health<sup>2</sup>
- The whole life policy is payable to age 121
- You do not need to provide proof of good health when converting your coverage

## Will my coverage amounts stay the same?

When no longer eligible for coverage under the group policy you may convert coverage for yourself, your spouse and your children. You may convert any amount up to the amount you previously held. Any additional benefits such as Waiver of Premium, Accidental Death and Dismemberment or Accelerated Death Benefit will not be converted.

## How do I convert my coverage?

Simply send in your Life Conversion Information Request Form to request an application within 31 days following the date any part of your group life insurance ends.

## What is the time period for conversion?

You must return the conversion application and pay the first premium within 21 days of the date the conversion packet was mailed to you.



### Request an application today!

The offer to convert your coverage will expire in 31 days



Return your Life Conversion Information Request Form to request an application and take advantage of a fixed whole life insurance rate for life! Please refer to your Life Conversion Information Request Form for a copy of conversion rates and fees.

<sup>1</sup>Minnesota employees may have the option of electing term life continuation in place of this conversion; contact your employer for more information.

<sup>2</sup>Your cost includes an annual policy fee based on the amount of coverage you choose to convert.

Insurance products are underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Home and Administrative Office: 20 Washington Avenue South, Minneapolis, MN 55401

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151671 02/15/2015



**LIFE INSURANCE ENROLLMENT/CHANGE**  
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
SFN 53803 (Rev. 03-2016)

Underwritten by Voya Financial (Carrier) Policy Number: 67389-7

**PART A EMPLOYER/EMPLOYMENT STATUS**

Organization Name	NDPERS Organization ID	Employment Status <input type="checkbox"/> Active Full-Time <input type="checkbox"/> Active Part-Time
-------------------	------------------------	--

This Change is due to: (Check all that apply)

New Hire (Date of Hire \_\_\_\_/\_\_\_\_/\_\_\_\_)  Annual Enrollment-Read below for Evidence of Insurability (EOI) requirements

Decrease Coverage  Marital Status Change (Date of Change \_\_\_\_/\_\_\_\_/\_\_\_\_)

Birth/Adoption (Date of Change \_\_\_\_/\_\_\_\_/\_\_\_\_)

**Effective Date**  
\_\_\_\_/01/20\_\_\_\_

**PART B EMPLOYEE INFORMATION**

Name (Last, First, Middle)	NDPERS Member ID
----------------------------	------------------

Last 4 Digits of SSN	Date of Birth
----------------------	---------------

**PART C EMPLOYEE COVERAGE**

**Basic Life**  Employee Only—Employer Provides \$3,500 of Basic Life Coverage at no expense to you

**Supplemental Life and AD&D Election:** When you are first eligible for supplemental life coverage, you can elect up to the Guaranteed Issue (GI) Limit of \$200,000 without providing evidence of insurability. Upon qualifying event or annual enrollment, you can increase your employee supplemental by a \$5,000 increment without Evidence of Insurability form (EOI). Evidence of Insurability form (EOI) must be completed for amounts larger than \$5,000 and approved by the Carrier.

I am applying for a TOTAL supplemental life coverage of: \$\_\_\_\_\_. (Increments of \$5,000)  Waive Additional Supplemental Life & AD&D coverage

**PART D DEPENDENT COVERAGE**

**Supplemental Dependent Life Insurance Election: Only available if you elected Supplement in Part C.** When you are initially eligible for dependent coverage, you can elect it without providing evidence of insurability. Upon qualifying event or annual enrollment, an Evidence of Insurability form (EOI) must be completed for approval by the Carrier.

\$5,000 for eligible spouse and \$5,000 for each eligible dependent child. **OR**  \$2,000 for eligible spouse and \$2,000 for each eligible dependent child.

Waive Supplemental Dependent Coverage

**PART E SPOUSE COVERAGE**

**Supplemental Spouse Life Election: Only available if you elected dependent coverage of \$2,000 or \$5,000 in Part D.** When you are initially eligible for supplemental spouse coverage, you can elect up to \$50,000 in coverage without providing evidence of insurability. Total spouse coverage up to \$100,000 is available if your spouse completes an Evidence of Insurability form (EOI) for approval by the Carrier. **Supplemental spouse coverage is limited to 50% of the employee's coverage amount.** Upon a qualifying event or annual enrollment, an Evidence of Insurability form (EOI) must be completed.

Total Amount of coverage \$\_\_\_\_\_. (Increments of \$5,000) Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Waive Supplemental Spouse Coverage

**PART F BENEFICIARY INFORMATION**

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855

**PART G AUTHORIZATION**

**READ THIS INFORMATION CAREFULLY AND PLEASE SIGN THIS FORM BEFORE SUBMITTING IT TO YOUR PAYROLL OFFICE**

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by the Carrier, provided I am actively at work.
- I understand that evidence of insurability may be required for coverage to become effective.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

**Part A Employer/Plan Sponsor**

Must be completed by your employer's authorized agent.

**Part B Employee Information**

For member identification, please provide all requested information.

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage. Indicate the TOTAL amount of coverage you are requesting.

YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

**Part C Employee Coverage**

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage. Indicate the TOTAL amount of coverage you are requesting.

YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE. Upon Retirement, Basic Life will be decreased to \$1,300.

**Part D Dependent Coverage**

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.  
YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

**Part E Spouse Coverage**

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.  
YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE

**Part F Beneficiary Information**

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855.  
IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

**Part G Authorization**

You must sign and date this section for this form to be valid.



**LIFE INSURANCE DESIGNATION OF BENEFICIARY**  
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
SFN 53855 (Rev. 01-2014)

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 • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657**  
**(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920**

<b>PART A MEMBER INFORMATION</b>						Policy Number: 67389-7
Name (Last, First, Middle)				NDPERS Member ID		
Last Four Digits of Social Security Number				Date of Birth		
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed						
<b>Effective Date:</b>						
<b>PART B DESIGNATION OF BENEFICIARY</b>						
<b>Primary Beneficiary(ies)</b> (If person enter: Last, First, Middle)	<b>Relationship</b>	<b>Gender</b>	<b>Social Security Number</b>	<b>Birth Date</b>	<b>% Share</b>	<b>Address</b>
<b>Must Equal 100%</b>						
<b>Contingent/Secondary Beneficiary(ies)</b> (If person enter: Last, First, Middle)	<b>Relationship</b>	<b>Gender</b>	<b>Social Security Number</b>	<b>Birth Date</b>	<b>% Share</b>	<b>Address</b>
<b>Must Equal 100%</b>						
<b>PART C MEMBER AUTHORIZATION</b>						
<p>I understand that this election revokes any previous life insurance beneficiary designations. I have read and understand the terms and conditions listed on page two (2) of this designation. I hereby certify that the information provided on this form is true and correct to the best of my knowledge.</p>						
_____				_____		
Member Signature				Date Signed		



**Part A Member Information**

Enter your name, NDPERS ID number, date of birth, last four digits of your Social Security Number, marital status, and effective date of change.

**Part B Designation of Beneficiary**

1. Use full legal name. (Example: "Anna May Smith," not Mrs. John Smith")
2. A member may designate contingent beneficiary (ies) who will receive benefits if the primary beneficiary (ies) predecease member.
3. If more than one person in a class (primary or contingent beneficiary) is named, members of that class will share equally in the benefits unless specific shares are designated. The total number of shares must equal 100 percent. The benefit will be distributed as directed by the designation. If a named beneficiary does not survive, the beneficiary's share will be distributed among any surviving beneficiaries, in the same proportion as the initial shares.
4. To file a death claim, a certified copy of the Death Certificate must be provided to NDPERS to process the claim.
5. Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established, or as allowed by law.
6. If an estate is named, specify whose estate such as: "Estate of the Insured." Full name and address of the executor must be included.

**TRUSTEE DESIGNATION:**

1. Trustee under the last will and testament of the insured, or his/her successors in trust, PROVIDED, HOWEVER, that if no claim is made by the Trustee within one year from the date of death of the insured or if the insured shall die leaving no last will and testament containing the trust covering this policy, the proceeds shall be payable to the estate of the insured. Payment of the proceeds of this policy to said Trustee or successors in trust shall fully and finally discharge the Company from all liability.
2. "The \_\_\_\_\_ Trust Company, trustee under written trust agreement date (month, date, year) \_\_\_\_\_, or its successor or successors in trust, and payment of the proceeds of this policy to said Trustee or successor or successors shall fully and finally discharge the Company from all liability." Full name and address of trust administrator must be included.

IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

**Part C Member Authorization**

You must sign and date this section for this form to be valid.



**ELECTION TO CONTINUE YOUR LONG TERM CARE INSURANCE COVERAGE**

Mail to: Unum Life Insurance Company of America  
LTC Customer Services  
2211 Congress Street  
Portland, Maine 04122

Policy Number:

**TO BE COMPLETED BY THE EMPLOYER**

Company Name \_\_\_\_\_ Plan Number \_\_\_\_\_

Company Data:

Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Company Address:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Employee Name:

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  Male

Employee Data:

Female

Person terminating group coverage:

Name(s) \_\_\_\_\_  Employee

Employee's Spouse or Domestic Partner (if applicable)

Reason person is terminating group coverage:  Termination of Employment  Death of Spouse or Domestic Partner

Divorce  Other

Date group coverage terminates:

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Current monthly premium payment:

Employee \$ \_\_\_\_\_ /month Spouse \$ \_\_\_\_\_ /month

Signature of Employer:

Date:

**TO BE COMPLETED BY THE EMPLOYEE**

If you are an insured employee, you may be eligible to continue your long term care insurance coverage after your group coverage terminates. If you wish to continue your coverage, please complete this form and return it to the insurer at the address listed above. This form must be completed and returned within the time period specified in your certificate. **You will be responsible for the entire cost of your coverage.** Unum will mail bills to you at the address you provide below.

Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Mailing Address:

Monthly \_\_\_\_\_ Quarterly (Paper) \_\_\_\_\_ Semi-Annually (Paper) \_\_\_\_\_ Annually (Paper) \_\_\_\_\_

Payment Options:  Automatic payment via checking account  (3x monthly rate)  (6x monthly rate)  (12x monthly rate)

Signature of Employee:

Date:

**TO BE COMPLETED BY THE EMPLOYEE'S SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)**

If you are the insured spouse or domestic partner or former spouse or domestic partner of the above employee, you may be eligible to continue your long term care insurance coverage after your group coverage terminates. If you wish to continue your coverage, please complete this form and return it to the insurer at the address listed above. This form must be completed and returned within the time period specified in your certificate. **You will be responsible for the entire cost of your coverage.** Unum will mail bills to you at the address you provide below.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Name:

Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Mailing Address:

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  Male

Data:  Female

Monthly \_\_\_\_\_ Quarterly (Paper) \_\_\_\_\_ Semi-Annually (Paper) \_\_\_\_\_ Annually (Paper) \_\_\_\_\_

Payment Options:  Automatic payment via checking account  (3x monthly rate)  (6x monthly rate)  (12x monthly rate)

Signature of Employee's Spouse/Domestic Partner:

Date:

**PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS**

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

## **Information About Continuing Your Long Term Care Insurance Coverage**

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### **Should The Certificate Of Insurance Be Kept?**

If you elect to continue your long term care coverage, you will not receive a new Certificate of Insurance. You should keep the Certificate of Coverage that was issued to you under the group plan.

### **Can Coverage Be Changed?**

You may apply at any time to increase coverage by filling out a new application, which includes evidence of insurability. Call Unum at (800) 227-4165 for assistance.

### **Where Should Premium Payments Be Sent?**

You must remit all premium payments directly to Unum. The address is:  
Unum Life Insurance Company of America  
P.O. Box 406933  
Atlanta, Georgia 30384-6933

**Your Certificate of Coverage sets forth in detail the rights and obligations of both you and the insurer. Please refer to your Certificate for more information including the number of days in your grace period, how long Unum will continue to pay for long term care benefits and when your coverage will terminate.**



**PROTECTION AGAINST UNINTENTIONAL LAPSE  
ADDITIONAL DESIGNATION  
GROUP LONG TERM CARE INSURANCE**

Your Name: \_\_\_\_\_

Your Social Security Number: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

You, the insured, will receive notice if any coverage for which you are required to pay the cost is about to terminate because you have not paid the required premiums.

You are required to provide your insurer with a written designation of at least one person, in addition to you, who is to receive the notice of cancellation of your coverage for nonpayment of premium OR sign a waiver electing not to designate a person. You have the right to change these designations. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to you. The designated person or persons will not receive the notice until 30 days after the premium is due and unpaid.

My designations are as follows:

Name: \_\_\_\_\_

Address: Street/P.O. Box: \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

Name: \_\_\_\_\_

Address: Street/P.O. Box: \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

Insured's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**WAIVER ELECTING NOT TO NAME AN ADDITIONAL DESIGNATION  
FOR PROTECTION AGAINST UNINTENTIONAL LAPSE**

I understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. **I elect NOT to designate any person to receive such notice.**

Insured's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this form to:**  
Group Long Term Care  
Unum Life Insurance Company of America  
2211 Congress Street, Portland, Maine 04122

**New Jersey and New York Residents – Age 62 and older:** Per New Jersey insurance code C.17:29C-1.2 and §3111 of the New York Insurance Laws, this form shall be delivered to Unum by certified mail, return receipt requested along with the completed Designee Acceptance form (on the back page of this form). Your Designee(s) must accept in writing that they are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from us.

Please retain a copy of this form for your records

**DESIGNEE ACCEPTANCE  
LONG TERM CARE INSURANCE**

This form needs to be completed by the Designee, if the named Insured is age 62 or over and a resident of New Jersey or New York.

**Insurance Applicant: Please complete this section prior to sending this form to your Designee for signature.**

Insured's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Prior to issuing a long term care policy; the Insured is required to provide the insurer with a written designation of at least one person, who is to receive the notice of cancellation of this policy for nonpayment of premium, in addition to the insured OR sign a waiver electing not to designate a person. You have been listed as one of the designees. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to the insured.

You must accept in writing that you are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from the insurer. Should you desire to terminate the status as a third party designee, you shall provide written notice to both the insurer and the insured.

Designee's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please retain a copy of this form for your records



**CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)**  
 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
 SFN 53512 (REV. 01-2014)

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

**PART A PARTICIPANT/QUALIFIED BENEFICIARY INFORMATION**

Name (Last, First, Middle)	PeopleSoft Employee ID (Required)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth	

**PART B CONTINUATION OF COVERAGE ELECTION / WAIVER**

**If you elect Medical Spending Continuation coverage, it will be in effect to the end of the current plan year, or December 31.**

Do you wish to continue your current participation in the NDPERS Flexcomp Plan Medical Spending Account?  Yes  No

- I wish to pre-pay the premium through the end of the plan year with pre-tax dollars deducted from my final pay checks.
- I will pay the premium plus a 2% administration fee with after-tax dollars through the remainder of the plan year.

**PART C AUTHORIZATION OF APPLICANT**

I have read the information in its entirety, **including the back page**, and agree to abide by the terms of the Plan Document. I certify, under penalties of perjury, that the information submitted on this form is true, correct and complete.

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 Date of Signature



### **Entitlement to COBRA Coverage**

Under provisions of the Internal Revenue Service (IRS) COBRA regulations, you have the opportunity to extend your participation in the Medical Spending Account to the end of the current plan year.

The employer has the responsibility to notify NDPERS of a participant's death, termination, or reduction in hours of employment.

Qualified Beneficiaries Your spouse or dependent(s) may elect to continue coverage in a medical spending account under the following circumstances:

1. Participant's death.
2. Divorce or legal separation.
3. A dependent child ceases to be a "dependent child" under the group health plan.

If you elect COBRA continuation, your premium payment will be based on the annual election amount in existence at the time of the qualifying event.

Under the law, it is the responsibility of the person seeking continuation coverage to inform NDPERS of a divorce, legal separation or a child losing dependent status within 60 days of the date of the event. If you are interested in COBRA continuation coverage, contact NDPERS for more information.

### **Length of COBRA Coverage**

You, your spouse or dependent(s), are eligible to receive continuation coverage until the end of the plan year, or December 31, in which the qualifying event occurred. If you have paid your premium through the end of the year on December 31 and have a balance in your account, you have the option to have eligible expenses incurred during the "grace period", from January 1 through March 15 of the new plan year, reimbursed from that remaining balance. You will have until April 30 to submit claims. Any amount remaining in your medical spending reimbursement account after the April 30 claims filing deadline is forfeited.

### **COBRA Coverage Premiums**

Employees who elect COBRA continuation coverage are permitted to pre-tax the COBRA premium and pre-pay the premium through the end of the current plan year from their final paychecks.

To pay the premium with after-tax dollars throughout the plan year, submit the premium amount plus a two percent (2%) administrative fee by the first of each month. If you fail to pay the premium on time, your coverage will terminate on the last day of the month for which a contribution was received.

**Continuation coverage under COBRA is provided subject to your eligibility. NDPERS reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.**

You will have 60 days from the date of this notice to inform NDPERS that you want continuation coverage.

**IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS OF THE DATE OF THIS NOTICE YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE**



**457 DEFERRED COMPENSATION PLAN ENROLLMENT/CHANGE FORM**  
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
SFN 3803 (Rev. 12-2014)

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

<b>PART A PARTICIPANT INFORMATION</b>	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID

<b>PART B PROVIDER INFORMATION</b>	
Name of Company (Required)	
Agent Name (Required)	Telephone Number

<b>PART C CHECK ALL THAT APPLY</b>	
<input type="checkbox"/> 1. New Application	<input type="checkbox"/> 9. Change in Agent only (Complete Part A, B & F)
<input type="checkbox"/> 2. Increase Deduction	<input type="checkbox"/> 10. USERRA Missed Contributions
<input type="checkbox"/> 3. Decrease Deduction	<input type="checkbox"/> 11. Lump sum Sick & Annual Leave (Form due at NDPERS by the 15 <sup>th</sup> of the month preceding payout date)
<input type="checkbox"/> 4. Suspend Deduction (Includes going from full-time to part-time)	
<input type="checkbox"/> 5. Change Employer: From: _____ To: _____	
<input type="checkbox"/> 6. Age 50 or older: Annual Catch-up	
<input type="checkbox"/> 7. Regular 3 Year Catch-up –457 Deferred Compensation Catch-up Worksheet Certification SFN 51501 MUST accompany this form	
<input type="checkbox"/> 8. Provider Change <b>YOU MUST complete 2 Participant Agreement forms:</b>	
1. One for the new provider & √ 'New Application' 2. One to stop contributions to old provider & √ 'Suspend Deduction'	

<b>PART D CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION</b>	
<b>Must be completed if you checked 1, 2, 6, 7, 8, 10, or 11 in Part C</b>	
A. Annual Gross Pay	\$ _____
B. Less Employer Retirement Contributions made under a IRC 414(h) arrangement (use most recent pay stub)	\$ _____
C. Includable Compensation (subtract B from A)	\$ _____
D. Maximum Annual Allowable Deduction:	
D 1. Lesser of 100% of Includable Compensation or annual maximum limit (see annual limits on back of form)	
Enter the lesser of D 1 but not less than the minimum annual deduction of \$300.00 (\$25.00) per month	\$ _____
E. Age 50 + catch-up (see annual limits on back of form)	\$ _____
F. Total D + E	\$ _____
G. Pay Period Deduction (F divided by number of pay periods in calendar year)	\$ _____

<b>PART E SALARY REDUCTION AUTHORIZATION.</b>	
<b>Must be completed if you checked 1, 2, 6, 7, 8, 10, or 11 in Part C</b>	
Authorization for deductions must be made in the month prior to the pay period in which the income is earned.	
I authorize my employer to reduce my salary in the amount of \$ _____ for the pay period beginning date (not date paid) _____.	
<b>(The signature date in Part F must be in the month prior to the pay period date entered here.)</b> (month, day, year)	
With regard to this agreement, the Participant acknowledges the following (read and initial each statement):	
_____	I understand that my salary will be reduced each pay period by the amount authorized above. The deduction can not be changed or stopped without an authorized participant agreement form returned to payroll from NDPERS.
_____	I understand the accumulated deferred salary is credited to my account and is not available to me or my beneficiary(ies) until I separate from service, unless, I should experience an unforeseeable emergency and a distribution is approved by the NDPERS Board. .
_____	I acknowledge that the Retirement Board makes no recommendation as to any provider and understand that the Retirement Board does not warrant or guarantee the investment performance of any provider.
_____	I understand that all compensation deferred under the Plan, and all earnings accruing thereof, shall be held for the exclusive benefit of myself or my Beneficiary, until such time as it is made available to me pursuant to the terms of the Plan.
_____	I understand that this agreement includes the beneficiary forms as executed with and maintained by my provider.

<b>PART F PARTICIPANT AUTHORIZATION</b>	
I verify that the foregoing statements are true and correct to the best of my knowledge and belief, and are subject to the laws and penalties governing any misrepresentations and fraud.	
_____	_____
Participant Authorization	Date
<b>(This date must be in the month prior to the date entered in Part E)</b>	



**ANNUAL LIMITS**

Annual Limit for 2015:	\$18,000
Age 50+ Limit for 2015:	\$24,000
Regular 3 Year Catchup:	\$36,000

**PART A PARTICIPANT INFORMATION**

For member identification, please provide all requested information.

**PART B PROVIDER INFORMATION**

If you check 'New Application in Part C, you must first select and contact one of the eligible providers for the plan. The provider representative you select will assist you in completing the required forms to open an account.

**PART C CHECK ALL THAT APPLY**

Check the applicable box(s).

**PART D CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION**

The minimum contribution is \$25.00 per month. The maximum regular annual contribution limit is the lesser of 100% of annual compensation or the annual maximum limit indicated above.

**PART E SALARY REDUCTION AUTHORIZATION**

The IRS regulations require you to make your deferral election in the month prior to the month the salary is earned.

**PART F PARTICIPANT AUTHORIZATION**

Sign where indicated. If you completed Part E, your signature must be dated in the month prior to the month entered in that section.



## 457 DEFERRED COMPENSATION PLAN QUICK ENROLLMENT/WAIVER

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
SFN 54362 (Rev. 03-2016)

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

### PART A EMPLOYEE INFORMATION

Name (Last, First, Middle)	NDPERS Member Id
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID

### PART B QUICK DEFERRED COMP PLAN & PEP ENROLLMENT

I understand that by electing to begin participation in the 457 Deferred Compensation Plan, I will reduce my wages by \$25.00 a **month** and vest in the employer's contributions to the Defined Benefit Retirement Plan, to which I am entitled based on my service credit and level of contribution (See vesting schedule on back of form). My contributions will be invested with the NDPERS Companion Plan.

(The minimum of \$25.00 is paid at \$12.50 per pay period for bi-weekly and semi-monthly payrolls.)

I authorize my employer to reduce my salary by \$25.00 a month for pay period date beginning        /        /       .  
**Month / Day / Year**

\_\_\_\_\_  
Participant Authorization

\_\_\_\_\_  
Date

(This date must be in the month prior to the Beginning Date entered in above )

### PART C PARTICIPANT ACKNOWLEDGEMENT

**With regard to this agreement, the Participant acknowledges the following (read and initial each statement).**

- \_\_\_\_ I understand that **by electing to participate, my salary will be reduced by \$25.00 per month.**
- \_\_\_\_ I understand that by participating in the deferred compensation plan and the NDPERS defined benefit retirement plan I am automatically enrolled in PEP and the applicable employer contribution is credited to my NDPERS member account.
- \_\_\_\_ I acknowledge that I have the right to increase or decrease the amount of contribution, change to another Provider company or suspend contributions at any time by completing the Participant Agreement for Salary Reduction form (SFN 3803).
- \_\_\_\_ I understand that the accumulated deferred salary is not available to me until I separate from service, or when I experience an approved unforeseeable emergency.
- \_\_\_\_ I acknowledge that the NDPERS Board makes no recommendation as to any fund investment and I understand that the NDPERS Board does not warrant or guarantee the investment performance of the funds offered by any provider.
- \_\_\_\_ I understand that all compensation deferred under the Plan, and all earnings accruing thereof, shall be held for the exclusive benefit of myself or my beneficiary, until such time as it is made available to me pursuant to the terms of the Plan.

### PART D WAIVER OF PARTICIPATION

I understand that by declining to participate in the 457 Plan at this time, I **will not vest in the employer's contributions** to the Defined Benefit Retirement Plan, to which I am entitled, based on my service credit. I understand that I am eligible to begin participation at a later date and will automatically vest in the employer's contribution when I participate in a deferred compensation plan.

**I elect to decline to participate at this time.**

\_\_\_\_\_  
Participant Authorization

\_\_\_\_\_  
Date

**This form only applies if your employer participates in the Defined Benefit Retirement Plan**

By electing to enroll in the Deferred Compensation Program through your employer at a minimum required monthly contribution of \$25.00, you automatically enroll in the Portability Enhancement Provision (PEP) for the NDPERS Defined Benefit Retirement Plan. Your NDPERS retirement account will automatically be credited with the percentage of the employer contribution to which you are entitled based upon your years of credited service. As you attain additional service credit, you must increase your 457 contribution amount to the corresponding percentage of salary to achieve maximum vesting.

<b>Service Credit</b>	<b>Minimum Contribution</b>	<b>Maximum Vesting %</b>
0-12 Months	\$25	1%
13-24 Months	\$25	2%
25-36 Months	\$25	3%
37+ Months	\$25	4%

**INSTRUCTIONS:**

**PART A: EMPLOYEE INFORMATION**

This form must be completed regardless of whether the employee elects to participate or declines to participate in the 457 Deferred Compensation Plan and Portability Enhancement Provision (PEP).

For member identification, please provide all requested information.

**Part B: QUICK ENROLLMENT IN DEFERRED COMP/PEP**

**This section should be completed if the employee elects to participate in the Deferred Compensation Plan and the Portability Enhancement Provision (PEP).** The employee's signature in this section **will authorize** a reduction in the employee monthly wage and contribution to a deferred compensation plan. The minimum of \$25.00 is paid at \$12.50 per pay period for bi-weekly and semi-monthly payrolls.

The employee must sign and date this section. (This date must be in the month prior to the date entered above )

**PART C: PARTICIPANT ACKNOWLEDGEMENT**

The employee must read each item and indicate acknowledgement by initialing all boxes on the left side of the statements.

**Part D: WAIVER OF PARTICIPATION**

The employee must sign and date this section only if the employee waives participation in the Deferred Compensation Plan.