



EMPLOYER VERIFICATION OF INSURANCE COVERAGE
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53621 (Rev. 06-2015)

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

Instructions: Please complete Part A and B information and forward the form to the former employer to verify coverage in Parts C, D, E, and to sign Part F. These Parts must be completed by an authorized staff employee of the employer. This information is used to determine eligibility for insurance provided through the North Dakota Public Employees Retirement System (NDPERS). This information must be returned to NDPERS accompanied by the applicable enrollment form(s).

PART A NDPERS MEMBER INFORMATION	
NDPERS Member Name (Last, First, Middle)	NDPERS Member ID (If applicable)
PART B EMPLOYEE AND EMPLOYER INFORMATION	
Employee Name (Last, First, Middle)	Employer Name
Date Employment Terminated	
PART C HEALTH INFORMATION	
Month and Year the Employee is Covered on Employer Group Insurance Billing: From: ___/___/___ Through: ___/___/___	
Does employee currently participate in the employer sponsored HEALTH plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, Current level of coverage: _____	
Has employee been covered under COBRA? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, Beginning date of COBRA: ___/___/___ Ending date of Health Coverage: ___/___/___	
PART D DENTAL INFORMATION	
Last Month and Year the Employee is Covered on Employer Group Insurance Billing: ___/___	
Does employee currently participate in the employer sponsored DENTAL plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, Current level of coverage: _____	
Has employee been covered under COBRA? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, Beginning date of COBRA: ___/___/___ Ending date of Dental Coverage: ___/___/___	
PART E VISION INSURANCE	
Last Month and Year the Employee is Covered on Employer Group Insurance Billing: ___/___	
Does employee currently participate in the employer sponsored VISION plan? <input type="checkbox"/> No <input type="checkbox"/> Yes, Current level of coverage: _____	
Has employee been covered under COBRA? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, Beginning date of COBRA: ___/___/___ Ending date of Vision Coverage: ___/___/___	
PART F EMPLOYER CERTIFICATION	
Signature of Authorized Personnel	Date of Signature
Telephone Number:	