



**DEPENDENT CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA)**  
 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  
 SFN 53883 (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 COBRA MEMBER INFORMATION</b> (Spouse or Dependents Losing Coverage)   |                     |   |                      |                                  |                        |
| Name (Last, First, Middle)  |                     |   | NDPERS Id            |                                  |                        |
| Last Four Digits of Social Security Number  |                     |   | Date of Birth        |                                  |                        |
| <b>PART B TRANSFERRING FROM POLICY HOLDER</b>   |                     |   |                      |                                  |                        |
| Name (Last, First, Middle)  |                     |   | NDPERS Member ID     |                                  |                        |
| Last Four Digits of Social Security Number  |                     |   | Date of Birth        |                                  |                        |
| <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 |                      | Date of Event:                   |                        |
| <input type="checkbox"/> Death of current contract holder   |                     | <input type="checkbox"/> Contract holder entitled to Medicare   |                      |                                  |                        |
| <b>PART D DEPENDENT ELECTION</b>  |                     |   |                      |                                  |                        |
| Indicate Plan: <input type="checkbox"/> Health Insurance <input type="checkbox"/> Dental Insurance <input type="checkbox"/> Vision Insurance  |                     |   |                      |                                  |                        |
| Do you wish to continue your current NDPERS insurance coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes  |                     |   |                      | 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.  |                     |   |                      |                                  |                        |
| 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. |                     |   |                      |                                  |                        |
| <i>Name</i>   | <i>Relationship</i> | <i>Gender</i>   | <i>Date of Birth</i> | <i>Social Security Number</i>    | <i>Mailing Address</i> |
|   |                     |   |                      |                                  |                        |
|   |                     |   |                      |                                  |                        |
| <b>PART E PAYMENT METHOD</b>  |                     |   |                      |                                  |                        |
| Dependents losing eligibility may continue the NDPERS Group Insurance Coverage at their own expense for a maximum of 36 months.   |                     |   |                      |                                  |                        |
| <u>PAYMENT OF PREMIUM:</u>  |                     |   |                      |                                  |                        |
| 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.  |                     |   |                      |                                  |                        |
| <b>Failure to remit your premium by the due date will result in loss of coverage.</b>   |                     |   |                      |                                  |                        |
| <b>PART F DEPENDENT AUTHORIZATION</b>   |                     |   |                      |                                  |                        |
| I have read this application in its entirety 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's Signature   |                     |   |                      | Date                             |                        |



**PART A COBRA MEMBER INFORMATION**

For dependent identification, please provide all requested information.

**PART B POLICY HOLDER'S INFORMATION**

For member identification, complete all requested information.

**PART C QUALIFYING COBRA EVENT**

Indicate the reason for this COBRA event.

**PART D DEPENDENT ELECTION**

Indicate which group insurance plan this election pertains to. If continuing coverage, indicate the level of coverage and covered family members.

**PART E PAYMENT METHOD**

If you do not elect to have your insurance premium deducted from a bank, you will be sent a monthly billing for personal payment.

**PART F DEPENDENT AUTHORIZATION**

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