



**ANNUAL FLEXCOMP ENROLLMENT 2025 PLAN YEAR**

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 17759 (Rev. 10-2024)

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657

(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

**PLAN YEAR BEGINNING JANUARY 1, 2025 THROUGH DECEMBER 31, 2025**

**PART A EMPLOYEE INFORMATION**

Employee Name (Last, First, Middle)		NDPERS Member ID (Required)
Empl ID (PeopleSoft Payroll System-Required)	Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Organization Name		NDPERS Organization ID

**PART B PREMIUM CONVERSION- DECLINE TO PRE-TAX LIFE INSURANCE PREMIUM**

Group Life Employee Supplemental Insurance Premium up to \$50,000 of coverage will automatically be pre-taxed. <input type="checkbox"/> I decline this action.	
Employee's Signature (Electronic signature is not accepted)	Date

**PART C PREMIUM CONVERSION-PRE-TAX INSURANCE PREMIUMS**

I elect to pre-tax the following insurance premiums, excluding the NDPERS administered group life insurance:

<b>Company/Product Name</b>		
<input type="checkbox"/> AFLAC-Accident	<input type="checkbox"/> Central United – Cancer	<input type="checkbox"/> Delta Dental - NDPERS
<input type="checkbox"/> AFLAC-Cancer	<input type="checkbox"/> Colonial Life – Accident	<input type="checkbox"/> Total Dental Admin-Elite Choice (TDA)
<input type="checkbox"/> AFLAC-Hospital Confinement	<input type="checkbox"/> Colonial Life - Cancer	<input type="checkbox"/> Superior Vision - NDPERS
<input type="checkbox"/> AFLAC-Hospital Intensive Care	<input type="checkbox"/> Colonial Life- Medical Bridge	<input type="checkbox"/> US Able – Accident Elite
<input type="checkbox"/> AFLAC-Lump Sum Critical Illness		<input type="checkbox"/> US Able – Cancer Care Elite
<input type="checkbox"/> AFLAC-Specified Health Event Plan		<input type="checkbox"/> US Able – Hospital Confinement
<input type="checkbox"/> Custer Health Unit Only –Dental	<input type="checkbox"/> Custer Health Unit Only - Vision	

**PART D MEDICAL SPENDING REIMBURSEMENT ACCOUNT**

Medical Spending Annual Maximum: \$3,200	What is the total ANNUAL amount you want payroll deducted for the Plan Year?	\$	ANNUAL AMOUNT
--	--	----	---------------

**PART E DEPENDENT CARE REIMBURSEMENT ACCOUNT**

Dependent Care Annual Maximum: Single: \$5,000 Married: \$5,000 Married filing separate tax: \$2,500	What is the total ANNUAL amount you want payroll deducted for the Plan Year?	\$	ANNUAL AMOUNT
--	--	----	---------------

**PART F AUTHORIZATION**

I have read the information in its entirety, INCLUDING THE BACK PAGE, and I hereby apply for the options listed above. I understand this agreement revokes my prior election. I authorize NDPERS to adjust my pay as required by my election. I understand that the benefit options I have elected will remain in force throughout the plan year unless I have a change in status event allowed under IRC Section 125. If my required contributions for the elected insurance premiums are increased or decreased while this agreement is in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I understand that I cannot participate in the flex comp medical spending account if I am covered on the NDPERS High Deductible Health Plan (HDHP) with a Health Savings Account (HSA).

Employee's Signature (Electronic signature is not accepted)	Date
---	------

## **ENROLLMENT FORM INSTRUCTIONS**

Form should be completed to participate in the flexcomp plan for the period January 1 through December 31, 2025. To maintain participation, employees must enroll in the plan each year.

### **PART A EMPLOYEE INFORMATION**

**For employees paid through the Office of Management and Budget (OMB) payroll system:** Your NDPERS Member ID is required on the form along with your Empl ID number which can be found on your pay stub or direct deposit advice.

**For employees paid through their agencies payroll system:** A PeopleSoft employee ID number is not required on the form.

### **PART B PREMIUM CONVERSION-DECLINE PRE-TAX LIFE INSURANCE PREMIUM**

Your employee supplemental life insurance premium up to the first \$50,000 in coverage will automatically be pre-taxed. If you wish pay the premium with after tax dollars, sign and date in Part B.

### **PART C PREMIUM CONVERSION-PRETAX INSURANCE PREMIUMS**

Check any eligible insurance premiums you wish to have payroll deducted on a pre-tax basis.

### **PART D MEDICAL SPENDING REIMBURSEMENT ACCOUNT**

Enter amount you want payroll deducted per pay period. Enter the number of payroll checks you will receive from January 1 through December 31. Multiply the amount to be deducted per pay period by the number of payroll periods in the year and enter this amount in Total Salary Redirection for the Plan Year. Your Medical Spending election cannot exceed the plan year maximum \$3,200.

### **PART E DEPENDENT CARE REIMBURSEMENT ACCOUNT**

Enter the amount you want payroll deducted per pay period. Enter the number of payroll checks you will receive from January 1 through December 31. Multiply the amount to be deducted per pay period by the number of payroll periods in the year and enter this amount in Total Salary Redirection for the Plan Year. Your election cannot exceed the maximum limit of \$5,000 for a single parent, \$5,000 for a married couple filing a joint tax return or \$2,500 for a married person filing a single tax return.

### **PART F AUTHORIZATION**

Sign and date the form. Electronic signatures will not be accepted.

**Return form to your agency's payroll/human resource department. Retain a photocopy for your records.**