(Rev. 03-16-2022)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

DEFERRED RETIREMENT CHECKLIST

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59044

APPLICATION FOR DEFERRED RETIREMENT BENEFITS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 59044 (Rev. 08-2021)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A PARTICIPANT IDENTIFICATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Preferred Email Address	Telephone Number

PART B APPLICATION TO DEFER RETIREMENT BENEFITS

NDPERS Deferred Retirement Effective

- ☐ Date to be later determined
- ☐ Normal Retirement Date
- ☐ Other_____/ 1 /_____

PART C SICK LEAVE CONVERSION (DEFINED BENEFIT PLAN ONLY)

Do you wish to purchase all or part of your unused sick leave into retirement service credit?

☐ No ☐ Yes

If Yes, complete and return the Conversion Of Unused Sick Leave Application – Defined Benefit SFN 58358 prior to the last day of the month in which you terminate.

PART D AUTHORIZATION

I elect to defer my retirement benefits and retiree health insurance credit as indicated in PART B. **I understand that I must submit an application to commence retirement benefits to NDPERS at least 30 days before distribution of my first retirement check.**

Member's Signature(Electronic signatures will not be accepted)	Date

Please refer to the "Group Retirement Plan" sheet.

Part A Participant Identification

For member identification, please provide all requested information.

Part B Application to Defer Retirement Benefits

You may defer your retirement benefits to a later date. This is a date you tentatively wish to commence benefits. You have the option to delay your benefits until you are required by law to receive minimum required distributions. Whether vested or not, you can leave your Member Account Balance intact with NDPERS. Interest continues to compound on your Member Account Balance until you begin receiving a pension.

Part C Sick Leave Conversion

This section is to be completed ONLY if you participate in the Defined Benefit Plan. Defined Contribution Plan members are not eligible to purchase unused sick leave.

Part D Authorization

YOU MUST SIGN AND DATE PART D TO VALIDATE THIS FORM.

58358

CONVERSION OF UNUSED SICK LEAVE APPLICATION– DEFINED BENEFIT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58358 (Rev. 01-2022)
NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A PARTICIPANT IDENTIFICATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)

PART B NOTICE TO MEMBER

I understand that I only have the opportunity to convert my unused sick leave upon (1) changing to any position in which I "no longer accrue unused sick leave," (2) changing to a "non-contributing no longer accruing part-time or temporary employee" in the NDPERS retirement, or (3) "terminating" employment. Payments can be made to NDPERS as an after-tax payment through a personal check or as a pre-tax payment through a direct rollover or trustee-to-trustee transfer of an eligible fund towards the retirement portion of the sick leave conversion. I have had the opportunity to speak to a financial planner and NDPERS regarding this election and to ask any questions. **I understand this election must be made in the same month in which I become eligible and prior to disbursement of any retirement benefits.** My election regarding payment is indicated in Part D or Part E.

PART C HOURS OF UNUSED SICK LEAVE

Projected number of **Hours** of unused sick leave _____

Convert eligible unused sick leave hours to **Months** [formula = hours ÷ 173.3 = months] (rounded up) _____

Number of months I elect to **Purchase** and convert to retirement service credit _____

PART D APPLICATION FOR AFTER TAX PAYMENT THROUGH PERSONAL CHECK

☐ I elect to convert my unused sick leave and to pay for it through an after-tax payment. I understand that NDPERS will provide the cost for the sick leave conversion following my termination of employment. I understand that my full payment and completed form must be received by NDPERS by the 15th of the month following my month of termination and prior to my first retirement check date as not to delay the payment of this first benefit.

PART E APPLICATION FOR PRE-TAX PAYMENT THROUGH DIRECT ROLLOVER/TRANSFER

☐ I elect to convert my unused sick leave and to pay for the retirement portion of the conversion through a pre-tax payment by direct rollover or transfer from an eligible fund source. I understand that by electing this option, NDPERS will determine the estimated cost 60 days prior to my termination date and will provide this information to me. I understand that all completed forms, rollover/transfer funds, and any personal payment must be received by NDPERS by the 15th of the month following my month of termination. If I elect to use a direct rollover or transfer, I will submit payment for the RHIC portion by personal check. The final cost will be calculated upon my termination. If there is a difference between the sick leave balance or conversion payment amount and the amount that I paid, only the amount of sick leave available as of the date of termination will be added to my member record. The funds for the over-payment cannot be returned due to the pre-tax nature of the funds. My member account balance will be credited with the full amount of funds received from the rollover or transfer. If an underpayment occurred, I will pay the remaining amount by the 15th of the month following my month of termination date. **I authorize my employer to document my expected salaries for the 60 days prior to my termination of employment under section F.**

PART F EMPLOYER SALARY VERIFICATION – COMPLETE IF PART E ELECTED BY MEMBER

Indicate Month(s) and Projected Salary		
Month	**Year**	**Indicate Projected Gross Salary**
		$
		$
		$

The salaries above are the projected gross salaries that this individual is expected to earn within 60 days of the employment termination date. To the best of my knowledge and belief, the information that I have provided on this form is correct.

Signature of Authorized Agent (Electronic Signature will not be accepted)	Date

PART G MEMBER ELECTION

To the best of my knowledge and belief, the information that I have provided on this form is correct. **I understand this Application must be received and date stamped at NDPERS on or before the last working day of the month in which I either terminate employment or no longer accrue sick leave. I understand NDCC 54-52-02.9 prohibits temporary employees from purchasing any additional service credit. Late applications will be VOID.**

Member's Signature (Electronic Signature will not be accepted)	Date

INSTRUCTIONS

PART A PARTICIPANT IDENTIFICATION

Enter your name, NDPERS member ID, last four digits of social security number, and date of birth.

PART B NOTICE OF MEMBER

Read this section carefully! This section contains important information that you need to know before making an election.

- If you "**terminate**" employment; change employment to a "**non-contributing no longer accruing part-time or temporary employee**"; or change to **any position in which you are "no longer accruing sick leave" without terminating eligible employment**, you must submit SFN 58358 Conversion of Unused Sick Leave Application in the same month in which this change occurs.

- If you change employment and are no longer participating in the NDPERS retirement plan (ex. change to ND University System or TFFR retirement plan) but continue to accrue unused sick leave, you may not purchase your unused sick leave under the NDPERS retirement.

- If you transfer employment from one participating employer to another participating employer (within 31 days) without terminating eligible "contributing" employment, NDPERS will record your unused sick leave upon receipt of application. You must submit the Transfer of Unused Sick Leave Verification SFN 53404 within sixty (60) days of leaving employment with your former employer.

PART C HOURS OF UNUSED SICK LEAVE

Enter number of months you have eligible and number of months you wish to convert.

PART D APPLICATION FOR AFTER TAX PAYMENT THROUGH PERSONAL CHECK

Complete this section to authorize payment for your unused sick leave through a personal check.

PART E APPLICATION FOR PRE-TAX PAYMENT THROUGH DIRECT ROLLOVER/TRANSFER

Complete this section to authorize a payment for your unused sick leave through a direct rollover/transfer from an eligible fund source.

PART F EMPLOYER SALARY VERIFICATION – COMPLETE IF PART E ELECTED BY MEMBER

If Part E is elected by the member, the employer must provide written certification of the projected gross salaries to be reported to NDPERS during the final 60 days of employment.

PART G MEMBER ELECTION

The member must sign and date this section to verify their election.

2560

DESIGNATION OF BENEFICIARY FOR THE GROUP RETIREMENT PLAN

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 2560 (Rev. 12-2023)

Clear Form

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*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.

PART A MEMBER INFORMATION

Name (Last, First, Middle)	☐ Married ☐ Single ☐ Divorced ☐ Widowed	NDPERS Member ID
Date of Birth (mm/dd/yyyy)	Last Four Digits of Social Security Number	
Spouse Name (Last, First, Middle)		Spouse Gender ☐ Male ☐ Female

PART B PLAN

☐ **ALL DEFINED BENEFIT PLANS (*Update beneficiaries for all plans*)**
Mark plan below only if beneficiary designation should be applied to a specific plan:

☐ Main / Main 2020 ☐ Public Safety with Prior ☐ Job Service
☐ Judges ☐ Public Safety without Prior ☐ National Guard
☐ Highway Patrol ☐ State Public Safety

☐ **401(a) DEFINED CONTRIBUTION PLAN***

**Please Note*: *You must update beneficiaries for the 457 Deferred Compensation Plan directly with your selected provider company.*

PART C PRIMARY BENEFICIARY(IES) – Complete all sections

Name	Relationship	Social Security Number*	Birth Date (mm/dd/yyyy)	% Share	Address
			Total must equal	**100%**	

PART D CONTINGENT/SECONDARY BENEFICIARY(IES)

Name	Relationship	Social Security Number*	Birth Date (mm/dd/yyyy)	% Share	Address
			Total must equal	**100%**	

PART E SPOUSE AUTHORIZATION

If you are married and designate a beneficiary other than or in addition to your spouse, your spouse must complete this section. If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to the listed beneficiary(ies).

If a member with three or more years of credited service is married, North Dakota law requires the spouse's consent before benefits can be paid other than to the member's spouse. (NDCC 30.1-05-02). If spouse's consent is given, please be advised, that if your primary beneficiary election is someone in addition to or in lieu of your spouse, there is no monthly pre-retirement death benefit provision.

I consent to the above retirement beneficiary(ies) designated by the above named NDPERS member.

Spouse's Signature (Electronic Signature will not be accepted)	Date

PART F MEMBER AUTHORIZATION

I understand that this election revokes any previous retirement account beneficiary designations. I understand that, if married, any initiation of dissolution or annulment of my marriage may void this designation. 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.

Member's Signature (Electronic Signature will not be accepted)	Date

PROVISIONS FOR ALL BENEFITS

1. This "Designation of Beneficiary" is for the group Retirement Plan only. To designate beneficiary (ies) for the group Life Insurance Plan, please complete a “Life Designation of Beneficiary SFN 53855”.

2. **EFFECTIVE WHEN FILED:** This designation will be effective when properly executed and received in the NDPERS office.

3. **SUBJECT TO LAWS AND REGULATIONS:** This designation is subject to the governing statutes and to rules and regulations established by the Retirement Board of the North Dakota Public Employees Retirement System. The acceptance of the designation by NDPERS does not establish that a survivor benefit will be payable. Whether or not a benefit is payable and the amount thereof will be determined at the time of death under laws and regulations then applicable.

4. **WHO IS ELIGIBLE TO BE A BENEFICIARY:** Any person, whether or not a relative, or a church or charity may be designated as a primary or contingent beneficiary. A member may also designate his or her estate as beneficiary and the benefits will be distributed according to his or her testamentary will or according to the state laws for interstate distribution. A creditor of a member (such as a bank, credit union, loan company, etc.) may not be named a beneficiary as a means of providing security for a debt. (N.D.C.C. 28-22-19)

5. **DESIGNATED BENEFICIARIES:** All beneficiary designations shall equal 100% of the benefit. If the benefit is being divided amongst multiple beneficiaries and the total share does not equal 100%, NDPERS shall amend the designations in order to reach the 100% in total, but in no circumstance will NDPERS amend the beneficiary designation by more than one (1) %. If an amendment is necessary, the additional percentage shall be credited to the eldest beneficiary.

   If shares are not designated, NDPERS will distribute benefits equally to the named beneficiary(ies). As this distribution may not reflect the member’s preference, we recommend the member be sure to designate the percent of share for each listed beneficiary.

6. If there are no surviving beneficiaries, all benefits will be paid to your estate.

7. A **certified** copy of the death certificate must be sent to NDPERS to process a claim.

PROVISIONS FOR RETIREMENT BENEFITS ONLY

1. **DEATH OF ACTIVELY EMPLOYED MEMBER:**

   A. If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to whoever is the listed beneficiary(ies).

   B. If a member dies after completing three years of service, his/her retirement account will be distributed pursuant to N.D.C.C. 54-52-17(6) and N.D.C.C. 39-03.1-11(6).

2. **DEATH OF RETIREE:** Benefits will be paid to the named beneficiary based upon the option selected by the member at retirement. If there are no surviving beneficiaries, any remaining cash value will be paid to your estate.

3. **DEATH OF SURVIVING SPOUSE (in accordance with North Dakota law):** A lump sum payment of any remaining cash value will be paid to the spouse's named beneficiary. If there are no surviving beneficiaries, any remaining cash will be paid to the spouse's estate.

NOTE: Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established.

14120

CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 14120 (Rev. 03-2024)

Clear Form

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PART A APPLICANT INFORMATION

Name (Last, First, Middle)		Date of Birth		Applicant NDPERS Member ID (if known)
Last Four Digits of Social Security Number	Address	City	State	ZIP Code
Applicant Gender ☐ Male ☐ Female	Applicant's Home/Cell Number	Relationship to Current Contract Holder ☐ Self ☐ Spouse/Dependent		
Home/Personal Email Address				
Name of current contract holder (Last, First, Middle)				NDPERS Member ID

PART B EFFECTIVE DATE OF CHANGE

Change Effective Date (first of month after loss of active group coverage): _____
Actual effective date of coverage will be determined by NDPERS based on plan provisions.

PART C QUALIFYING COBRA EVENT/REASON FOR CHANGE

☐ Termination of current contract holder
☐ Divorce from current contract holder
☐ Death of current contract holder
☐ Marriage
☐ Attained Age 26
☐ Contract holder entitled to Medicare
☐ Remove Dependent
☐ Cancel COBRA (indicate plan(s) below)
☐ ACA ineligibility

Select the coverage(s) to be continued and check level of coverage.

☐ Health: ☐ Self Only ☐ Family ☐ Decline/Cancel

☐ Dental: ☐ Self Only ☐ Family ☐ Applicant & Spouse ☐ Applicant & Child(ren) ☐ Decline/Cancel

☐ Vision: ☐ Self Only ☐ Family ☐ Applicant & Spouse ☐ Applicant & Child(ren) ☐ Decline/Cancel

List all eligible covered individuals for the plan(s) listed above. Attach separate sheet if more room is needed.

***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.

Name (Last, First, Middle)	Relationship to Applicant	Gender	Date of Birth	Social Security Number*
	Self			

Continue to Page 2 for Payment Method and Authorization

PART D PAYMENT METHOD

If a payment method is not selected, it will be your responsibility to submit payment by the 1st of each month. NDPERS does not direct bill for premiums. **Failure to remit your premium by the due date of the 1st of the month will result in loss of COBRA continuation coverage.**

NOTE: Your COBRA continuation coverage will not be in effect until premiums due are paid up to date or the bank account information is provided below. Members have 45 days from when NDPERS receives the election to remit COBRA payment to NDPERS.

☐ Withhold from bank account. Complete bank information below.

Please write clearly and verify information for accuracy. Form will be returned if information provided is illegible.

Financial Institution Name	Financial Institution Routing Number (must be 9 digits)

Telephone Number

Type of Account & Account Number

☐ Checking Account Number

☐ Savings Account Number

Attach a Voided Check Here for Checking Account (Optional).
Deposit slips will not be accepted.

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written request with member signature must be submitted. The request must provide the contract holder's name, last four digits of social security number or NDPERS Member ID, and effective date. NDPERS must receive a cancellation request by the end of the month prior to the effective date. Cancellations will only be made at the end of the month. NDPERS cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

PART E APPLICANT AUTHORIZATION

I have read this application in its entirety, including the back page, and certify the information is accurate and complete. I understand and agree that any false statements or omissions may constitute a fraudulent act or intentional misrepresentation and may void or retroactively cancel any benefit issued based on this application.

Signature of Applicant (Electronic Signatures will not be accepted)	Date

Please review Page 3 for Additional Information and Instructions

.

PART A APPLICANT INFORMATION

For applicant identification, please provide all requested information.

PART B EFFECTIVE DATE OF CHANGE

- Indicate the qualifying event date or requested change effective date (actual effective date of coverage will be determined by NDPERS based on plan provisions).

PART C QUALIFYING COBRA EVENT/REASON FOR CHANGE

1. Check the box that describes the event that qualifies you for continuation coverage.

2. Indicate the group insurance plan(s) you are electing for COBRA continuation coverage.

3. Check the level of coverage. If you are not applying for the coverage, check the decline/cancel box.

4. List all covered individuals, including yourself. You may elect COBRA continuation coverage for only those family members that were covered on the plan at the time of the qualifying event.

PART D PAYMENT METHOD

Withhold from bank account: You must complete the banking information.

If a payment option is not selected, you will be required to submit premium by the 1st of each month. You will not receive a billing from NDPERS. Your COBRA continuation coverage will not be effective until the initial premium payment is received. **Failure to remit your premium by the due date of the 1st of the month will result in loss of insurance coverage.**

PART E APPLICANT AUTHORIZATION

Employees terminating employment, or individuals otherwise losing eligibility may continue their NDPERS Group Health Coverage at their own expense subject to the following:

1. You must be a member of the plan at time of loss of eligibility.
2. Your spouse or any other dependent(s) applying for this COBRA continuation coverage must be a member of the plan at the time of loss of eligibility.
3. You must complete and submit this election form to NDPERS within 60 days from your last date of coverage.
4. There must not be a lapse in coverage, i.e. premiums must be paid to ensure continuous coverage.

If you do not choose continuation coverage, your group health insurance coverage will end on the last day of the month for which premiums were paid.

You must sign and date this form for it to be valid. Electronic signatures will not be accepted.

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS

50134

AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 50134 (Rev. 03-2024)

Clear Form

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PART A PARTICIPANT IDENTIFICATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)

PART B MEMBER AUTHORIZATION

NDPERS requires that the same bank account be used for all premiums with that payment method. I authorize the following insurance premium(s) to be withheld from the Financial Institution indicated in Part C of this authorization:

☐ Health & Prescription Drug Plan ☐ Life ☐ Dental ☐ Vision

This authorization will remain in effect until the member notifies NDPERS in writing to cancel it in such time as to afford NDPERS a reasonable opportunity to act on it. **The premium amount will be deducted from the bank account by the 5th (fifth) day of each month or the next working day if the 5th (fifth) is on a weekend or a holiday**. Your financial institution may charge an additional fee for this service.

I agree to the terms listed on this authorization**. I authorize NDPERS to update any other insurance premiums currently being withheld from another bank account with this new Financial Institution information, even if the insurance is not marked above.** Any insurances with an alternative method of payment (not withheld from a bank account) will remain the same unless marked above.

Member's Signature (Electronic Signature will not be accepted)	Date

PART C FINANCIAL INSTITUTION INFORMATION

Please write clearly and verify information for accuracy. Form will be returned if information provided is illegible.

Financial Institution Name	Financial Institution Routing Number (must be 9 digits)

Type of Account & Account Number

☐ Checking Account Number

☐ Savings Account Number

Attach a Voided Check Here for Checking Account (Optional).
Deposit slips will not be accepted.

IMPORTANT NOTICE - This form is to be used only for North Dakota Public Employees Retirement System Group Insurance Deductions. **THIS FORM ONLY AUTHORIZES DEDUCTIONS FROM YOUR ACCOUNT.**

INSTRUCTIONS AND CONDITIONS

If you wish to have your monthly insurance premiums deducted from your savings or checking account, you must complete this form to authorize this action. The North Dakota Public Employees Retirement System (NDPERS) requires that the same bank account be used for all premiums with this payment method. The financial institution may be any bank, savings bank, savings and loan association or similar institution, or Federal or State chartered credit union.

PART A PARTICIPANT IDENTIFICATION

For member identification, please provide all requested information.

PART B MEMBER AUTHORIZATION

Check the type of insurance premium(s) you are requesting to be withheld from your bank account. Any insurances currently set up to be withheld from a bank account will be updated to the new bank information provided even if not marked in this section. Sign and date the form.

PART C FINANCIAL INSTITUTION INFORMATION

You may attach a voided check if you select a checking account.

CANCELLATION INSTRUCTIONS

When entered in your record with the North Dakota Public Employees Retirement System, this authorization will remain in effect until canceled by written notice by you to the North Dakota Public Employees Retirement System, or in the event of your death. The financial organization should also be notified if you cancel this agreement.

The financial organization may cancel their agreement by providing you a written notice 30 days in advance of the cancellation date. You must advise the North Dakota Public Employees Retirement System if this authorization is canceled. The financial organization cannot cancel this authorization by advice to the North Dakota Public Employees Retirement System.

The form is due back in our office by the 15th of the month prior to the month the new account will take effect.

CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53512 (Rev. 09-2021)

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

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 (mm/dd/yyyy)

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 understand that if I have elected to pre-pay the premium from my final paychecks, that NDPERS will contact my employer to notify them of my election and to discuss termination processing. I certify, under penalties of perjury, that the information submitted on this form is true, correct and complete.

Applicant's Signature (Electronic Signatures will not be accepted)	Date

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

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 3803 (Rev. 12-2023)

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3803

Clear Form

PART A MEMBER INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Organization Name	NDPERS Organization ID

PART B PROVIDER INFORMATION

Name of Company **(Required)**	
Agent Name **(Required)**	Telephone Number

PART C CHECK ALL THAT APPLY

☐ 1. New Application
☐ 2. Increase Deduction
☐ 3. Decrease Deduction
☐ 4. Suspend Deduction (Includes full-time to part-time) Last Date of Employment _____/_____/_____ *(date required)*
☐ 5. Age 50 or older: Annual Catch-up
☐ 6. Regular 3 Year Catch-up –**457 Deferred Compensation Catch-up Worksheet SFN 51501 MUST accompany this form**
☐ 7. Provider Change **YOU MUST complete 2 Participant Agreement forms:**
   1. **One for the new provider & √ 'New Application' 2. One to stop contributions to old provider & √ 'Suspend Deduction'**
☐ 8. Change in Agent only (Complete Part A, B & F)
☐ 9. USERRA Missed Contributions
☐ 10. Lump sum Sick & Annual Leave ☐ Exclude Regular Monthly Deduction

PART D CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION

Must be completed if you checked 1, 2, 3, 6, 9, or 10 in Part C

A. Annual Gross Pay $_____
B. Less Employer Retirement Contributions made under an IRC 414(h) arrangement (use most recent pay stub) $_____
C. Includable Compensation (subtract B from A) $_____
D. Maximum Annual Allowable Deduction:
   D1. Lesser of 100% of Includable Compensation or annual maximum limit (see annual limits on back of form)
   Enter the lesser of D1 but not less than the minimum annual deduction of $300.00 ($25.00) per month $_____
E. Pay Period Deduction (D divided by number of pay periods in calendar year) $_____

PART E SALARY REDUCTION AUTHORIZATION

Must be completed if you checked 1, 2, 3, 6, 9, or 10 in Part C

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.

Amount Per Pay Period (must be higher than $25/month) $	Pay Period Beginning Date (Not Date Paid) mm/dd/yyyy

(The signature date in Part F must be in the month prior to the pay period date entered here.)

With regard to this agreement, the Participant acknowledges the following:

- I understand that my salary will be reduced each pay period by the amount authorized above. The deduction cannot 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.
- I authorize NDPERS to contact my employer to confirm my last date of employment for any lump sum payout (#10 above), if not provided, and the North Dakota Office of Management and Budget, if necessary, to ensure the authorized amount is withheld from my paycheck.

PART F PARTICIPANT AUTHORIZATION

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.

This form must be dated in the month prior to a lump Sum payout (Part C #10) or the date listed in Part E.

Participant's Signature (Electronic Signature will not be accepted)	Date (Must be prior to the date listed on Part E)

ANNUAL LIMITS

Annual Limit for 2024:	$23,000
Age 50+ Limit for 2024:	$30,500
Regular 3 Year Catchup:	$46,000 Regular 3 Year Catchup must be within three (3) year **prior to the year in which you retire.**

PART A MEMBER 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). If you mark Box #10 for a lump sum payout, please indicate if your regular monthly deduction for that same month should be excluded. NDPERS requires that you also enter your last date worked or authorize NDPERS to contact your employer in order for your lump sum deduction to be entered correctly.

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.