DISABILITY RETIREMENT CHECKLIST

	RETIREMENT FORMS – Required for Benefit Payment	SFN
☐	APPLICATION FOR DISABILITY RETIREMENT BENEFITS	18000
☐	DISABILITY RETIREMENT OCCUPATIONAL DEMANDS (Completed by EMPLOYER)	54398
☐	DISABILITY RETIREMENT ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY	54399
☐	**LEGIBLE PHOTOCOPIES** OF BIRTH CERTIFICATE, SPOUSE'S BIRTH CERTIFICATE & MARRIAGE CERTIFICATE	
☐	AUTHORIZATION FOR DIRECT DEPOSIT FOR ANNUITY PAYMENTS	18379
☐	DESIGNATION OF BENEFICIARY FOR THE GROUP RETIREMENT	2560
☐	WITHHOLDING ALLOWANCE ELECTION FOR PENSION PAYMENTS	51506
	RETIREMENT FORMS – Optional	**SFN**
☐	CONVERSION OF UNUSED SICK LEAVE APPLICATION– DEFINED BENEFIT (complete only if buying unused sick leave for retirement service credit)	58358
	INSURANCE FORMS– Required	**SFN**
	Health - Continuation of Coverage	
☐	CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA) (Complete only for family members electing individual coverage if currently covered on NDPERS Dakota Plan or HDHP plan)	14120
☐	RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA) (Complete if currently covered on NDPERS Dakota Plan or HDHP Plan)	53799
	Health - Medicare Coverage	
☐	RETIREE HEALTH INSURANCE APPLICATION WITH MEDICARE (If either you or a dependent is over age 65)	59562
☐	MEDICARE PRESCRIPTION DRUG PLAN (PDP) INDIVIDUAL ENROLLMENT FORM (One required for each member that will be on the Dakota Retiree Plan and **cannot** be signed or submitted more than **90 days** prior to the requested effective date of coverage)	58860
	Life - Vision - Dental - Long Term Care - Flexible Medical Spending	
☐	RETIREE LIFE INSURANCE APPLICATION (If currently enrolled, complete to continue coverage)	53622
☐	WAIVER OF PREMIUM DISABILITY CLAIM – LIFE INSURANCE	
☐	RETIREE VISION\DENTAL INSURANCE ENROLLMENT, CHANGE, OR CANCEL (Complete if continuing, enrolling, or canceling coverage)	53504
☐	AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION (Complete if your pension benefit is not large enough for an insurance premium deduction or if your dependent is electing their own Single COBRA Policy)	50134
☐	CONTINUATION OF COVERAGE IN MEDICAL SPENDING ACCOUNT (COBRA) – (Complete if continuing coverage for the rest of the plan year)	53512
☐	457 DEFERRED COMPENSATION PLAN ENROLLMENT/CHANGE	3803

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18000

Clear Form

APPLICATION FOR DISABILITY RETIREMENT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 18000 (Rev. 08-2021)

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 IDENTIFICATION

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
Daytime Telephone Number	Home Email Address

PART B OTHER BENEFITS

Are you eligible to receive the following benefits? Please check and complete the appropriate boxes.

Yes	No	Benefits	Date Benefits Began	Date Benefits Terminate	Amount	Paid Weekly	Paid Monthly
☐	☐	Workers Compensation Benefits?					
☐	☐	Unemployment Compensation Disability?					
☐	☐	Sick Pay?					
☐	☐	Social Security Benefits?					
☐	☐	Retirement Income (Current or Past Employers?)					

Has Social Security Been Applied For? ☐ Yes ☐ No	Has Worker's Compensation Benefits Been Applied For? ☐ Yes ☐ No

PART C APPLICATION FOR DISABILITY BENEFITS

SECTION 1 RETIREMENT PAYMENT OPTION (Check One)

Main System or Public Safety	Highway Patrol or Judges	Defined Contribution Plan
☐ Single Life ☐ 50% Joint Survivor/Life ☐ 100% Joint Survivor/Life ☐ 10 Year Term Certain/Life ☐ 20 Year Term Certain/Life	☐ Normal Retirement ☐ 100% Joint Survivor/Life ☐ 10 Year Term Certain/Life ☐ 20 Year Term Certain/Life	☐ Periodic Retirement Payment **A TIAA Distribution Form MUST be completed and accompany this application.**

SECTION 2 RETIREE HEALTH INSURANCE CREDIT OPTION (Check One)

☐ I elect the standard retiree health credit option specific to the retirement payment option selected in section 1.

☐ If married and selected the Single Life, 20 or 10 Year Term Certain, or a Defined Contribution Periodic payment; I elect the following alternate actuarially reduced retiree health credit option.

(Check One): ☐ 50% Joint Survivor Life
☐ 100% Joint Survivor Life

Name (Last, First, Middle)	NDPERS Member ID

PART D SICKNESS OR INJURY DATA

Date of Sickness or Injury	Date You First Noticed Symptoms	Date You First Saw a Physician For This Sickness or Injury

Cause of Disability

Name of Treating Physician (If more than one, list on separate sheet of paper)

Address	City	State	ZIP Code

If Hospitalized For Sickness or Injury, Give Name of Hospital	Date Admitted	Date Released

Are You Bed Confined?	Are You House Confined?	Have You Ever Had The Same Kind of Sickness or Injury Before?
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes (Specify date, physician's name and address below)

Date	
Physician	
Physician's Address	

Date of Accident?	Time of Accident?	Was Accident Work Related?	Where Did The Accident Occur?

Date You Were First Able To Leave Home For Any Purpose?	Date You Were First Able To Do Any Part Of Your Work, Supervisory or Otherwise?

PART E EDUCATION

Last Year Completed	Name of School	
Last Year in School	Degree/Certificate	Additional Training
Attitude Towards School ☐Like ☐Dislike	Favorable Courses	

PART F MILITARY SERVICE

Branch	Date (mm/dd/yyyy) From To	Discharge ☐Honorable ☐General ☐Other (Specify)

Duties/Responsibilities

Rank	Special Training

Service Connected Disabilities

Name (Last, First, Middle)	NDPERS Member ID

PART G WORK HISTORY (List Most Recent First)

Employer		Supervisor
Job Title(s)		
Dates (mm/dd/yyyy) From To	Salary	Duties
Employer		Supervisor
Job Title(s)		
Dates (mm/dd/yyyy) From To	Salary	Duties
Employer		Supervisor
Job Title(s)		
Dates (mm/dd/yyyy) From To	Salary	Duties

Release of Information

To all physicians and other medical professionals, hospitals, and other medical-care, institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators:

You are authorized to provide MidDakota Clinic and any benefit plan administrators, consumer reporting agencies, attorneys, and independent claim administrators acting on MidDakota Clinic's behalf with information concerning medical care, advice, treatment, or supplies provided the patient, including information relating to mental illness and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administrating claims for benefits.

In understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. If this authorization is given in connection with a claim for disability or life insurance benefits, I understand that it is valid for the duration of the claim.

I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I elect to receive the retirement benefits and health credit as indicated in PART C. I understand I must submit a photocopy of my birth certificate. (If married, also submit a photocopy of spouse's birth certificate & marriage certificate)

I understand that this application for Disability Retirement SFN 18000 must be received by NDPERS at least 30 days before distribution of my first retirement check and within 12 months of termination of NDPERS covered employment.

Member's Signature (Electronic Signatures will <u>not</u> be accepted)	Date

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DISABILITY RETIREMENT OCCUPATIONAL DEMANDS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 54398 (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

This form should be completed in an objective manner by the employee's immediate supervisor or by another employing authority possessing comprehensive knowledge regarding the occupational demands of the employee's job. This form is then submitted to the treating physician for review in completing the Attending Physician's Statement. Both forms must be returned to NDPERS.

PART A PARTICIPANT IDENTIFICATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Preferred Email Address	Telephone Number
Job Description **(Please attach a copy of the employee's job description)**	

PART B PHYSICAL DEMANDS

Indicate the number of times per day for:	**Lifting***	**Carrying****	Indicate the percent of day each activity is performed:			
1-5 pounds			Sitting	%	Outside work	%
6-10 pounds			Standing	%	Working with others	%
11-25 pounds			Walking	%	Working around others	%
26-50 pounds			Inside work	%	Working alone	%
51-100 pounds			Additional Comments			
100 pounds or more						

*Includes pushing and pulling effort while stationary
**Includes pushing and pulling effort while walking

What are the average hours per day worked on this job?	
What are the average days per week worked on this job?	

Is overtime required?
☐ No ☐ Yes

If Yes, Hours Per Day	If Yes, Days Per Week

Indicate extent of performance of each of the following:

	Often	Significant	Seldom	Never
Ascending and descending stairs	☐	☐	☐	☐
Ascending and descending ladders	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐
Reaching below shoulders	☐	☐	☐	☐

(Continued)

Name (Last, First, Middle)	NDPERS Member ID

Occupational Requirements:
☐ Far Vision ☐ Talking
☐ Near Vision ☐ Depth Perception
☐ Hearing ☐ Other (Explain)_____

Did the employer request that the agency provide accommodations to assist employee in meeting the physical demands of the employee's job?
☐ No ☐ Yes

If Yes, please explain the type of accommodations provided.

PART C EMOTIONAL STRESS

Does the employee have to answer to customer complaints?
☐ Often
☐ Sometimes
☐ Not at all

The employee is expected to perform the job at a normal, average pace…..
☐ Most of the time
☐ Some of the time
☐ Occasionally Percent of the Time

The employee is expected to perform the job at a rapid pace….
☐ Most of the time
☐ Some of the time
☐ Occasionally Percent of the Time

Must the employee depend upon the assistance of others in order to accomplish daily tasks?
☐ No ☐ Yes

If Yes, how often?

☐ Most of the time	☐ Occasionally Percent of the Time

How close must the employee work with fellow workers?
☐ Very closely
☐ Significant contact
☐ Minor contact

How many employees does this employee supervise?

Is employee routinely subject to close supervision?
☐ No ☐ Yes

Does the employee's job consist primarily of prescheduled activities, or of tasks that arise randomly during the day?
☐ Primarily prescheduled
☐ Primarily random

What percentage of the employee's time is spent meeting deadlines set by other?

How much responsibility does the employee have for the overall performance of his/her particular department:
☐ 100 percent
☐ Great deal
☐ Significant
☐ Minor

(Continued)

Name (Last, First, Middle)	NDPERS Member ID

In your opinion, what degree of emotional stress is this employee subject to during the performance of his/her job?

- ☐ Great
- ☐ Significant
- ☐ Some
- ☐ Very Little

The above questions, both involving physical demands and emotional stress, require primarily objective answers. Your subjective and/or supplementary comments would also be appreciated.

PART D CERTIFICATION

Completed by (Please Print)			
Title			
Daytime Telephone Number			
Address	City	State	ZIP Code
Signature (Electronic Signature will not be accepted)		Date	

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54399

DISABILITY RETIREMENT ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 54399 (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

Under the Disability Retirement Disability Plan, an employee is eligible to receive benefits if medically disabled from performing the duties of any occupation the employee may be qualified for based on individual training, education, experience, and past job history.

The patient is responsible for the completion of this form without expense to the employer.

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 PHYSICIAN'S STATEMENT

In order to determine benefit eligibility and rehabilitation, answer the following questions.

HISTORY

Date symptoms first appeared or accident happened?	Date patient ceased work because of disability	Has patient ever had same or similar condition? ☐Yes ☐No

PRESENT CONDITION

Subjective Symptoms	Objective Findings
Diagnosis	**Prognosis**

TREATMENT

Date of First Visit / /	Date of Last Visit / /	Frequency of Visits	Date Patient was Last Examined / /

EXTENT OF DISABILITY

1. Is the employee totally disabled from any occupation as defined above? ☐No ☐Yes
2. If the disability is not considered total and permanent, do you anticipate a release to their regular occupation? ☐No ☐Yes- When?
3. If you answered "no", do you anticipate a release to a less physically and/or emotionally demanding occupation? ☐No ☐Yes-When?_____
   If yes, please complete the physical capacities evaluation on the back side of this form, this will provide us with the physical limitations placed on the employee.
4. If the employee is totally disabled as defined above, would you feel it appropriate to consider VOCATIONAL and/or MEDICAL REHABILITATION? ☐No ☐Yes
   If yes, please complete the physical capacities evaluation on the back side of this form, this will provide us with the physical limitations placed on the employee.

MENTAL CONDITION

1. Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐No ☐Yes

Complete the appropriate section below if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.

CARDIAC

Functional Capacity (American Heart Association): ☐Class 1 (No limitation) ☐Class 2 (Slight limitation) ☐Class 3 (Marked limitation) ☐Class 4 (Complete limitation)	Blood Pressure

VISUAL IMPAIRMENT

		O.D.	O.S.	Month	Day	Year
What was vision at last observation?	With Glasses					
	Without Glasses					

(Continued)

PART C PHYSICAL CAPACITIES EVALUATION

IMPORTANT: Please complete the following items based on your clinical evaluation, other testing results, patient discussions, and/or job analysis. Any item that you do not believe you can answer should be marked N/A (not available).

In an eight hour workday, claimant can: (Check time for each activity)

	1 hour	2 hours	3 hours	4 hours	5 hours	6 hours	7 hours	8 hours
Sit	☐	☐	☐	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐	☐	☐	☐

If any of the above three require alternating positions, please indicate frequency

In terms of an eight hour workday, "occasionally" equals 0-33; "frequently" equals 34-36, "continuously" equals 67-100 percent.

Claimant can lift…	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐
Claimant can carry…	**Never**	**Occasionally**	**Frequently**	**Continuously**
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

Claimant can use hands for repetitive action such as

	Simple Grasping		Pushing and Pulling		Fine Manipulation	
Right	☐Yes	☐No	☐Yes	☐No	☐Yes	☐No
Left	☐Yes	☐No	☐Yes	☐No	☐Yes	☐No

Claimant can use feet for repetitive movements as in operating foot control

Right	☐Yes	☐No
Left	☐Yes	☐No
Both	☐Yes	☐No

Claimant is able to:	Not at all	Occasionally	Frequently	Continuously
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐

Restrictions of activities:	None	Mild	Moderate	Total
Unprotected heights	☐	☐	☐	☐
Being around marked changes in temperature and humidity	☐	☐	☐	☐
Driving automobile equipment	☐	☐	☐	☐
Exposure to dust, fumes, and gases	☐	☐	☐	☐

Remarks on Above, or other Functional Limitations

PART D CERTIFICATION

Name (print)	Degree	Daytime Telephone Number	
Mailing Address (print)	City (print)	State	ZIP Code
Signature of Attending Physician (Electronic Signature will not be accepted)		Date	

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

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

*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.

18379

AUTHORIZATION FOR DIRECT DEPOSIT FOR ANNUITY PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 18379 (Rev. 12-2021)

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

Clear Form

PART A PARTICIPANT IDENTIFICATION & AUTHORIZATION

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

Type of Account: ☐ Member ☐ Surviving Spouse ☐ Beneficiary ☐ Alternate Payee

I authorize the following amount to be deposited to the Financial Institution indicated in Part B of this authorization.

Amount of Benefit to be Deposited: ☐ 100% ☐ _____ % ☐ $_____

(If you do not select the amount of benefit to be deposited, NDPERS will deposit 100% into the account noted below.)

PART B FINANCIAL INSTITUTION INFORMATION

Please write clearly and verify information for accuracy. Form will be returned if information provided is illegible. NDPERS is not responsible for delayed payments.

Financial Institution Name	Financial Institution Routing Number ☐☐☐☐☐☐☐☐☐
Telephone Number	

Type of Account & Account Number (Select One)

☐ Checking Account Number

☐ Savings Account Number

Attach a Voided Check or Complete Part B.
Deposit slips will not be accepted.

PART C AUTHORIZATION & SIGNATURE

I authorize the North Dakota Public Employees Retirement System (NDPERS), third party administrators (TPAs), and the financial institution named on this form to initiate electronic fund transfer (EFT) of my retirement benefit(s) into my account as indicated below. I consent to the financial institution sharing my customer information with NDPERS and TPAs for the purpose of completing the EFT arrangement.

I authorize NDPERS and/or TPA to initiate, a reversal or debit entry for all or any portion of any credit entry made in error to my designated account, including but not limited to amounts transferred after my death. If the funds remaining in the designated account are insufficient to fully reimburse NDPERS or TPA for any credit entry made in error subsequent to my death, I authorize my financial institution to release to NDPERS or TPA any information in its possession regarding the manner and party responsible for any withdrawal or transfer of funds from the designated account made subsequent to the date of the credit entry made in error.

I authorize my financial institution to notify NDPERS or TPA of my death.

This authorization will remain in effect until I notify NDPERS or TPA in writing to cancel it in such time as to afford NDPERS or TPA a reasonable opportunity to act on it.

I understand this form is due back in the NDPERS Office by the 15th of the month prior to the month I want to begin my direct deposit. I agree to the terms listed on this authorization.

Signature of Annuitant/Payee (Electronic Signatures will not be accepted)	Date

INSTRUCTIONS AND CONDITIONS

IMPORTANT NOTICE - This form is to be used only for North Dakota Public Employees Retirement System (NDPERS) Benefit Payments.

You must complete this form to authorize NDPERS and the third party administrator (TPA) to send your retirement benefit payment(s) to your financial organization for deposit into your savings or checking account. NDPERS will forward your retirement payments and the TPA will reimburse your retiree health insurance credit (RHIC) payments to the institution you authorize. The financial organization may be any bank, savings bank, savings and loan association or similar institution, or Federal or State chartered credit union.

THIS FORM DOES NOT AUTHORIZE INSURANCE PREMIUM WITHDRAWALS FROM YOUR ACCOUNT.

PART A PARTICIPANT IDENTIFICATION

- For member identification, please provide all requested information.
- Check the type of retirement account in which payment is being authorized.
- Check if you want 100% or only a portion of your benefit to be direct deposited in the financial institution indicated in Part B.

PART B FINANCIAL INSTITUTION SECTION

Enter the name and routing number of your financial institution. Select checking or savings and indicate the associated account number for your funds to be deposited. You may attach a voided check if you would like to deposit your funds in a checking account.

Immediate credit will be given the first working day of each month through your correspondent bank account at the Bank of North Dakota.

CANCELLATION INSTRUCTIONS

When entered into your record with the North Dakota Public Employees Retirement System, this authorization will remain in effect until cancelled by written notice by you to the North Dakota Public Employees Retirement System. Your 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 cancelled. The financial organization cannot cancel this authorization by advice to the North Dakota Public Employees Retirement System.

PART C AUTHORIZATION & SIGNATURE

- Sign and date the form by the 15th of the month prior to the month in which you want direct deposit to begin.

YOU MUST SIGN AND DATE PART C TO VALIDATE THIS FORM

51506

WITHHOLDING ALLOWANCE ELECTION FOR PENSION PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 51506 (Rev. 09-2022)

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	

PART B INSTRUCTIONS & EFFECTIVE DATE

Tax Withholding is calculated for each account separately. One form is required for each account.

Check One

☐ Main Retirement Plan ☐ Public Safety/Law Enforcement ☐ Judge ☐ Highway Patrol
☐ Surviving Spouse or Beneficiary Account ☐ Job Service ☐ Alternate Payee

Effective Date*

PART C FEDERAL WITHHOLDING ALLOWANCE

You must complete Form W-4P and submit to NDPERS to elect federal tax withholding. Personal tax questions should be directed to your tax advisor, accountant, or the Internal Revenue Service Center.

- If you do not complete Form W-4P, NDPERS is required to withhold federal income tax as if your filing status is "Single" with no adjustments in Steps 2 through 4 on the Form W-4P.
- If you do not want federal tax withheld, you must write "*No Withholding*" on Form W-4P in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5.

Your current withholding election (or your default rate) remains in effect unless you submit a revised Form W-4P.

PART D NORTH DAKOTA STATE INCOME TAX WITHHOLDING

If you are not a North Dakota resident, the benefits are taxable in the state in which you live.

☐ 1. No North Dakota income tax withheld.

☐ 2. I elect to have ND income tax withheld from my payment in the amount of $ _____ per month.

PART E MEMBER AUTHORIZATION

I understand that if my tax withholdings are not sufficient I may be subject to penalties.

I understand this form is due back to NDPERS by the 15th of the month prior to the month in which my income tax withholding election is effective. *** If no date or an ineligible date is written in Part B above, NDPERS will use an effective date based upon your earliest eligibility.**

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

Your benefits from NDPERS are subject to federal and North Dakota State income tax withholding. Use this form and IRS Form W-4P to inform NDPERS of your income tax withholding elections. You are responsible for reviewing and adjusting, if necessary, the amount withheld for federal and state taxes each calendar year.

Once you make an election, it will remain in effect until you change or revoke it. You must file a new form to change the amount being withheld from your pension benefit.

If you choose not to have tax withheld or do not have enough tax withheld, you may have to make estimated tax payments to the Internal Revenue Service (IRS). You may be subject to penalties if your payments of estimated tax and/or withholding are not sufficient.

If you do not complete Form W-4P, NDPERS is required to withhold federal income tax as if your filing status is "Single" with no adjustments in Steps 2 through 4. For payments that began before January 1, 2023, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P. NDPERS is not required to withhold North Dakota state income tax.

Federal Income Tax Withholding

You must complete Form W-4P to withhold federal income tax. Federal income tax withholding applies to the taxable part of your benefit payment. By completing Form W-4P, you can also elect to have no income tax withheld or an additional amount withheld.

North Dakota Income Tax Withholding

For North Dakota residents, your NDPERS pension benefit is subject to state income taxes. If you are not a North Dakota resident, the benefits are taxable in the state in which you live.

1. You can elect not to have income tax withheld.

2. You can elect to have a fixed dollar amount of North Dakota State income tax withheld.

Personal income tax questions should be directed to your tax advisor, accountant, or the Internal Revenue Service Center.

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Periodic Pension or Annuity Payments

Give Form W-4P to the payer of your pension or annuity payments.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number

Address

City or town, state, and ZIP code

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See pages 2 and 3 for more information on each step, when to use the estimator at *www.irs.gov/W4App*, and how to elect to have no federal income tax withheld (if permitted).

Step 2: Income From a Job and/or Multiple Pensions/ Annuities (Including a Spouse's Job/ Pension/ Annuity)

Complete this step if you (1) have income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity. **See page 2 for examples on how to complete Step 2.**

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Complete the items below.

(i) If you (and/or your spouse) have one or more jobs, then enter the total taxable annual pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs less the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter "-0-" . . . $

(ii) If you (and/or your spouse) have any other pensions/annuities that pay less annually than this one, then enter the total annual taxable payments from all lower-paying pensions/ annuities. Otherwise, enter "-0-" . . . . . $

(iii) Add the amounts from items (i) and (ii) and enter the **total** here . . . . . $

TIP: To be accurate, submit a new Form W-4P for all other pensions/annuities if you haven't updated your withholding since 2021 or this is a new pension/annuity that pays less than the other(s). Submit a new Form W-4 for your job(s) if you have not updated your withholding since 2019.

Complete Steps 3–4(b) on this form only if (b)(i) is blank **and** this pension/annuity pays the most annually. Otherwise, do not complete Steps 3–4(b) on this form.

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $

Multiply the number of other dependents by $500 . . . . . $

Add other credits, such as foreign tax credit and education tax credits $

Add the amounts for qualifying children, other dependents, and other credits and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs or pension/annuity payments). If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable social security, and dividends . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the basic standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld from **each payment** . **4(c)** $

Step 5: Sign Here

Your signature (This form is not valid unless you sign it.) **Date**

General Instructions

Section references are to the Internal Revenue Code.

Future developments. For the latest information about any future developments related to Form W-4P, such as legislation enacted after it was published, go to *www.irs.gov/FormW4P*.

Purpose of form. Complete Form W-4P to have payers withhold the correct amount of federal income tax from your periodic pension, annuity (including commercial annuities), profit-sharing and stock bonus plan, or IRA payments. Federal income tax withholding applies to the taxable part of these payments. Periodic payments are made in installments at regular intervals (for example, annually, quarterly, or monthly) over a period of more than 1 year. Don't use Form W-4P for a nonperiodic payment (note that distributions from an IRA that are payable on demand are treated as nonperiodic payments) or an eligible rollover distribution (including a lump-sum pension payment). Instead, use Form W-4R, Withholding Certificate for Nonperiodic Payments and Eligible Rollover Distributions, for these payments/distributions. For more information on withholding, see Pub. 505, Tax Withholding and Estimated Tax.

Choosing not to have income tax withheld. You can choose not to have federal income tax withheld from your payments by writing "No Withholding" on Form W-4P in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Generally, if you are a U.S. citizen or a resident alien, you are not permitted to elect not to have federal income tax withheld on payments to be delivered outside the United States and its territories.

Caution: If you have too little tax withheld, you will generally owe tax when you file your tax return and may owe a penalty unless you make timely payments of estimated tax. If too much tax is withheld, you will generally be due a refund when you file your tax return. If your tax situation changes, or you chose not to have federal income tax withheld and you now want withholding, you should submit a new Form W-4P.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Have social security, dividend, capital gain, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

2. Receive these payments or pension and annuity payments for only part of the year.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you (or you and your spouse) receive. If you do not have a job and want to pay these taxes through withholding from your payments, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Payments to nonresident aliens and foreign estates. Do not use Form W-4P. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities, and Pub. 519, U.S. Tax Guide for Aliens, for more information.

Tax relief for victims of terrorist attacks. If your disability payments for injuries incurred as a direct result of a terrorist attack are not taxable, write "No Withholding" in the space below Step 4(c). See Pub. 3920, Tax Relief for Victims of Terrorist Attacks, for more details.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you have at least one of the following: income from a job, income from more than one pension/annuity, and/or a spouse (if married filing jointly) that receives income from a job/pension/annuity. The following examples will assist you in completing Step 2(b).

Example 1. Bob, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Bob also has a job that pays $25,000 a year. Bob has no other pensions or annuities. Bob will enter $25,000 in Step 2(b)(i) and in Step 2(b)(iii).

If Bob also has $1,000 of interest income, which he entered on Form W-4, Step 4(a), then he will instead enter $26,000 in Step 2(b)(i) and in Step 2(b)(iii). He will make no entries in Step 4(a) on this Form W-4P.

Example 2. Carol, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Carol does not have a job, but she also receives another pension for $25,000 a year (which pays less annually than the $50,000 pension). Carol will enter $25,000 in Step 2(b)(ii) and in Step 2(b)(iii).

If Carol also has $1,000 of interest income, then she will enter $1,000 in Step 4(a) of this Form W-4P.

Example 3. Don, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Don does not have a job, but he receives another pension for $75,000 a year (which pays more annually than the $50,000 pension). Don will not enter any amounts in Step 2.

If Don also has $1,000 of interest income, he won't enter that amount on this Form W-4P because he entered the $1,000 on the Form W-4P for the higher paying $75,000 pension.

Example 4. Ann, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Ann also has a job that pays $25,000 a year and another pension that pays $20,000 a year. Ann will enter $25,000 in Step 2(b)(i), $20,000 in Step 2(b)(ii), and $45,000 in Step 2(b)(iii).

If Ann also has $1,000 of interest income, which she entered on Form W-4, Step 4(a), she will instead enter $26,000 in Step 2(b)(i), leave Step 2(b)(ii) unchanged, and enter $46,000 in Step 2(b)(iii). She will make no entries in Step 4(a) of this Form W-4P.

If you are married filing jointly, the entries described above do not change if your spouse is the one who has the job or the other pension/annuity instead of you.

Multiple sources of pensions/annuities or jobs. *If you (or if married filing jointly, you and/or your spouse) have a job(s), do NOT complete Steps 3 through 4(b) on Form W-4P. Instead, complete Steps 3 through 4(b) on the Form W-4 for the job. If you (or if married filing jointly, you and your spouse) do not have a job, complete Steps 3 through 4(b) on Form W-4P for* ***only*** *the pension/annuity that pays the most annually. Leave those steps blank for the other pensions/annuities.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. Including these credits will increase your payments and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include amounts from any job(s) or pension/annuity payments. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than

Specific Instructions *(continued)*

having tax on other income withheld from your pension, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 6, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions.

This includes itemized deductions, the additional standard deduction for those 65 and over, and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from **each payment**. Entering an amount here will reduce your payments and will either increase your refund or reduce any amount of tax that you owe.

Note: If you don't give Form W-4P to your payer, you don't provide an SSN, or the IRS notifies the payer that you gave an incorrect SSN, then the payer will withhold tax from your payments as if your filing status is single with no adjustments in Steps 2 through 4. For payments that began before 2024, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P.

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1	Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income	1	$
2	Enter: { • $29,200 if you're married filing jointly or a qualifying surviving spouse; • $21,900 if you're head of household; • $14,600 if you're single or married filing separately }	2	$
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	3	$
4	If line 3 equals zero, and you (or your spouse) are 65 or older, enter: • $1,950 if you're single or head of household. • $1,550 if you're married filing separately. • $1,550 if you're a qualifying surviving spouse or you're married filing jointly and one of you is under age 65. • $3,100 if you're married filing jointly and both of you are age 65 or older. Otherwise, enter "-0-". See Pub. 505 for more information	4	$
5	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	5	$
6	**Add** lines 3 through 5. Enter the result here and in **Step 4(b)** on Form W-4P	6	$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to provide this information only if you want to (a) request federal income tax withholding from pension or annuity payments based on your filing status and adjustments; (b) request additional federal income tax withholding from your pension or annuity payments; (c) choose not to have federal income tax withheld, when permitted; or (d) change a previous Form W-4P. To do any of the aforementioned, you are required by sections 3405(e) and 6109 and their regulations to provide the information requested on this form. Failure to provide this information may result in inaccurate withholding on your payment(s). Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

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14120

CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 14120 (Rev. 10-2022)

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

Clear Form

PART A APPLICANT INFORMATION

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

PART B QUALIFYING COBRA EVENT/REASON FOR CHANGE

☐ Termination of current contract holder	☐ Marriage	☐ Remove Dependent
☐ Divorce from current contract holder	☐ Attained Age 26	☐ Cancel COBRA
☐ Death of current contract holder	☐ Contract holder entitled to Medicare	☐ ACA ineligibility

Change Effective Date: _____
Actual effective date of coverage will be determined by NDPERS based on plan provisions.

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

☐ Health Insurance:	☐ Self Only	☐ Family	☐ Waive		
☐ Dental Insurance:	☐ Self Only	☐ Family	☐ Applicant & Spouse	☐ Applicant & Child(ren)	☐ Waive
☐ Vision Insurance:	☐ Self Only	☐ Family	☐ Applicant & Spouse	☐ Applicant & Child(ren)	☐ Waive

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 Employee	Gender	Date of Birth	Social Security Number*
	Self			
	Spouse			

PART C PAYMENT METHOD

PAYMENT OPTION

☐ Withhold from bank account. Complete Authorization for Automatic Premium Deduction SFN 50134.

If a payment option is not elected, it will be your responsibility to submit payment by the 1st of the month. Your continuation coverage will not be effective until the initial premium payment is received. NDPERS does not bill for premium. **Failure to remit your premium by the due date will result in loss of insurance coverage.**

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written request must be submitted. The request must provide the contract holder's name, last four digits of social security number, 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 done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

PART D 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

.

PART A APPLICANT INFORMATION

For applicant identification, please provide all requested information.

PART B QUALIFYING COBRA EVENT/REASON FOR CHANGE

- Check the box that describes the event that qualifies you for continuation coverage.
- Indicate the qualifying event date or requested change effective date (actual effective date of coverage will be determined by NDPERS based on plan provisions).
- 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 required submit premium by the 1st of each month. Your continuation coverage will not be effective until the initial premium payment is received. You will not receive a billing from NDPERS. **Failure to remit your premium by the due date will result in loss of insurance coverage.**

PART D 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 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.

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS

RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53799 (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 MEMBER INFORMATION

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

PART B NDPERS GROUP HEALTH INSURANCE

Do you wish to continue your current coverage in the NDPERS Group Health Insurance Plan through COBRA Continuation?

☐ No ☐ Yes

If Yes at ☐ Current Level of Coverage; indicate level of coverage ☐ Single ☐ Family
☐ Reduced Level of Coverage (Self Only)

Employees terminating employment, or otherwise losing eligibility, may continue their NDPERS Group Health Coverage at their own expense for a maximum of 18 months 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 continuation coverage must be a member of the plan at 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.

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

PART C PAYMENT METHOD

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

CANCELLATION POLICY

To cancel NDPERS health coverage, a written request must be submitted. The request must provide the contract holder's name, social security number and effective date. NDPERS must receive a cancellation request by the end of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

RETIREMENT GROUP	PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE →	☐ Deduct from pension check ☐ Withhold from bank account (Complete SFN 50134)
☐ TIAA ☐ NDPERS DEFINED CONTRIBUTION ☐ EX-LEGISLATOR →	☐ Withhold from bank account (Complete SFN 50134)

PART D MEMBER AUTHORIZATION

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.

Signature of Member (Electronic Signature will not be accepted)	Date

PART A MEMBER INFORMATION

For member identification, complete all requested information.

PART B NDPERS GROUP HEALTH INSURANCE

If continuing coverage, indicate the level of coverage.

PART C PAYMENT METHOD

If continuing coverage, indicate which retirement group you are receiving benefits from and your method of payment.

PART D MEMBER AUTHORIZATION

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

59562

RETIREE HEALTH INSURANCE WITH MEDICARE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 59562 (Rev. 08-2021)

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

PART A MEMBER INFORMATION

Member Name (Last, First, Middle)			NDPERS Member ID
Last Four Digits of Social Security Number			Date of Birth (mm/dd/yyyy)
Spouse Name (Last, First, Middle)			
Address	City	State	ZIP Code
Daytime Telephone Number			

PART B LEVEL OF COVERAGE – CHOOSE ONE

☐ I **decline** health insurance coverage at this time
☐ Single Coverage (Self Only)
☐ Family Coverage (Self and other eligible family members)

PART C EFFECTIVE DATE & REASON

Effective Date of Change (mm/dd/yyyy) ☐

Actual effective date of coverage will be determined by NDPERS based on plan provisions.

☐ New Retiree
☐ Medicare Eligible
☐ Surviving Spouse
☐ Marriage (Date of Marriage ☐)
☐ Loss of Other Coverage (Attach a Certificate of Creditable Coverage AND complete Part E)
☐ Transfer from existing policy
☐ Remove Dependent/Spouse
☐ Add Dependent/Spouse Is this an adult child? ☐ No ☐ Yes, Please answer the following questions.
Is adult child eligible to enroll under their own or spouse's employer insurance plan? ☐ No ☐ Yes
Is adult child disabled? ☐ No ☐ Yes (If yes, must complete SFN 58556 and SFN 58798)

PART D DEPENDENT INFORMATION

List all family members to be covered under the plan, 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
d. 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.
e. 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.

Last Name First Name Middle Name	Date of Birth	Gender	Relationship	Marital Status	Medicare Part A*	Medicare Part B*	Effective Date
			Spouse		☐ YES ☐ NO	☐ YES ☐ NO	A: B:
					☐ YES ☐ NO	☐ YES ☐ NO	A: B:
					☐ YES ☐ NO	☐ YES ☐ NO	A: B:

PART E END STAGE RENAL DISEASE

Are you or spouse or any of your eligible dependents currently covered by Medicare due to End Stage Renal Disease? If yes, attach a notice from medical provider including individual diagnosis. This is necessary to determine eligibility under Medicare regulations.

☐No ☐Yes, Date of Initial Diagnosis: (mm/dd/yyyy)

PART F OTHER COVERAGE INFORMATION

Are you, your spouse or any of your Eligible Dependents currently or were previously covered by another insurance benefit plan(s)?

☐No, skip to next section

☐Yes, please complete this section AND include Certificate(s) of Coverage. Failure to provide documentation may affect your eligibility.

Other Coverage Name & Phone Number	Policy Number	Policyholder (Last, First, Middle)	Date of Birth	Policy Coverage Dates (mm/dd/yyyy)	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

If 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

NOTICE TO MEMBER

Please refer to the "Dakota Plan & Dakota Retiree Plan" information.

***If you checked YES, in order to continue or be eligible for coverage you MUST submit a photocopy of the applicable Medicare ID card(s) for both Parts A & B and complete the NDPERS Medicare Prescription Drug Plan (PDP) Individual Enrollment Form.** Therefore, any eligible Medicare member should not defer Part B of Medicare when he/she becomes eligible for it. The **NDPERS Medicare Prescription Drug Plan (PDP) Individual Enrollment Form** may be obtained on our website at http://ndpers.nd.gov/ or by calling NDPERS at 328-3900 or 1-800-803-7377.

The NDPERS Medicare Prescription Drug Plan (PDP) Individual Enrollment Form SFN 58860 cannot be signed or submitted to NDPERS more than 90 days prior to the requested effective date of coverage.

If you are drawing a pension from a NDPERS defined benefit plan (NDPERS/NDHPRS), the Teacher's Fund for Retirement (TFFR), or the Job Service Retirement Plan, you can have your health insurance premium deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.

If you are drawing a pension from TIAA or the NDPERS Defined Contribution Plan or you are an ex-legislator, your health insurance premiums must be withheld from a bank account.

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written request must be submitted. The request must provide the contract holder's name, last four digits of social security number, NDPERS Member Id and effective date. A NDPERS Disenrollment form is also required for any individual on Medicare. NDPERS must receive a cancellation request by the end of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

PART G PAYMENT METHOD

RETIREMENT GROUP			PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS	☐ TFFR	☐ Job Service	☐ Deduct from pension check (Option only available for NDPERS/NDHPRS, TFFR, Job Service)
☐ TIAA	☐ NDPERS Defined Contribution		☐ Withhold from bank account (Complete SFN 50134)
☐ Ex-Legislator	☐ Alternate Retirement System		

PART H MEMBER AUTHORIZATION

I authorize the Social Security Administration to furnish Sanford Health Plan with medical or other information acquired under the Title XVIII Program (MEDICARE) during the periods my contracts are in force. I authorize Sanford Health Plan, or its agent to receive medical information from physicians, hospitals, and other health care providers in order to assure appropriateness of claims payment.

I 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.

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

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Clear Form

58860

MEDICARE PRESCRIPTION DRUG PLAN (PDP) APPLICANT ENROLLMENT FORM

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58860 (Rev. 02-2024)

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

PART A RETIRED MEMBER INFORMATION

Member's Name (Last, First, Middle)	NDPERS Member ID

PART B APPLICANT INFORMATION AND EFFECTIVE DATE

Name of Applicant Requesting PDP Enrollment (Last, First, Middle)	Applicant NDPERS Member ID
Applicant Last Four Digits of Social Security Number	Applicant Date of Birth (mm/dd/yyyy)
Requested Effective Date	

PART C PERMANENT RESIDENCE ADDRESS & TELEPHONE NUMBER

Street Address			PO Box
City	State	Zip Code	Telephone Number

PART D PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card.
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A & Part B to join the NDPERS Medicare prescription drug plan.

NAME OF BENEFICIARY:

MEDICARE CLAIM NUMBER SEX

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) ____/____/____

MEDICAL (PART B) ____/____/____

(Continued to back. Signature required.)

Humana Group Medicare (PDP) contracts with the Federal government. This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Humana Group Medicare may end that enrollment.

You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778.

Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Humana Group Medicare will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

This information is not a complete description of benefits. Contact Humana Group Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Release of Information

By joining this Medicare prescription drug plan, I acknowledge that Humana Group Medicare can release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

I also acknowledge that Humana Group Medicare can release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

I understand this enrollment form cannot be signed or submitted more than 90 days prior to the effective date of coverage.

Signature of Applicant Enrolling in NDPERS PDP (Electronic signatures will not be accepted)	Today's Date

Humana Group Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Humana Group Medicare depends on contract renewal.

PDF form cannot be signed, dated, or submitted to NDPERS 90 days prior to the requested effective date of coverage.

53622

RETIREE LIFE INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53622 (Rev. 09-2021)

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 MEMBER INFORMATION

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 NDPERS GROUP LIFE INSURANCE

Effective Date (mm/dd/yyyy)

☐ I elect **NOT** to Continue my Group Life Insurance

☐ I elect **To** continue my Group Life Insurance: (Check appropriate coverages below

- ☐ Basic Life
- ☐ Supplemental Life*: ☐ At Current Level of Coverage ☐ At a Reduced Level of Coverage: $_____.00
- ☐ Dependent Life*: ☐ At Current Level of Coverage ☐ At a Reduced Level of Coverage: $_____.00
- ☐ Spouse Supplemental Life*: ☐ At Current Level of Coverage ☐ At a Reduced Level of Coverage: $_____.00

* Any supplemental coverage will end when the member turns 65. Carrier may offer to port or convert this coverage.

☐ Beneficiary(ies) Update

PART C PAYMENT METHOD

RETIREMENT GROUP	PAYMENT OPTION (must select one)
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE →	☐ Deduct from my Pension Check ☐ Withhold from bank account (MUST Complete SFN 50134)
☐ NDPERS DEFINED CONTRIBUTION ☐ TIAA ☐ EX - LEGISLATOR →	☐ Withhold from bank account (MUST Complete SFN 50134)

PART D DESIGNATION OF BENEFICIARY

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.

PRIMARY BENEFICIARY(IES)

Name	Relationship	Social Security Number*	Date of Birth	% Share must = 100%	Address

CONTINGENT BENEFICIARY(IES)

Name	Relationship	Social Security Number*	Date of Birth	% Share must = 100%	Address

PART E MEMBER AUTHORIZATION

I authorize all physicians and other medical professional, hospitals, and other medical care institution, insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators to provide ING Employee Benefits and any benefit plan administrator, consumer reporting agencies, attorneys and independent claim administrators action on ING Employee Benefits behalf with information concerning medical care, advice, treatment or supplies provide the patient including information on mental illness and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand the carrier will offer to port my term life policy(ies) or convert to a whole life policy(ies). I understand that if I elect to continue my coverage through NDPERS, I cannot port or convert the coverage with the carrier.

I 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.

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

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Part A Member Information

For member identification, please provide all requested information.

Part B NDPERS Group Life Insurance

Indicate the effective date of your election.

Check the appropriate box(es) to elect the levels of coverage you had as an active employee and wish to continue. You must continue the basic life to continue the employee supplemental, the employee supplemental to continue dependent life, and the dependent life to continue 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 as an active employee or elect to decrease your level of coverage. NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Please note that any supplemental insurances will end when the member turns 65, at which time, the carrier may offer to port the term life policy(ies) or convert to a whole life policy(ies).

Part C Payment Method

If you are drawing a pension from a NDPERS defined benefit plan (NDPERS/NDHPRS), the Teacher's Fund for Retirement (TFFR), or the Job Service Retirement Plan, you can have your life insurance premium deducted from your pension check. If your pension check is not large enough, you must have the premium withheld from a bank account.

If you are drawing a pension from TIAA or the NDPERS Defined Contribution Plan or you are an ex-legislator, your life insurance premiums must be withheld from a bank account.

Part D Designation of Beneficiary

Use full legal name. (Example: "Anna May Smith," not Mrs. John Smith")

A member may designate contingent beneficiary(ies) who will receive benefits if the primary beneficiary(ies) predecease member**.**

If you have more than two designated beneficiaries in either the primary or contingent beneficiary sections, please submit a typed attachment and include your name, NDPERS Member ID, last four digits of your social security number, date of birth, signature, and date.

If more than one person in a class (primary or contingent beneficiary) is named, they will share equally in the benefit unless specific shares are designated. If specific shares are designated, they must equal 100 percent. The benefit will be distributed as directed by the designation. If a named beneficiary does not survive, the share will be distributed among any surviving beneficiaries in proportion to the shares designated. **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.

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

ESTATE DESIGNATION

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 E Member Authorization

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

RESET FORM

WAIVER OF PREMIUM DISABILITY CLAIM - EMPLOYEE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Submit at voya.com/claims *(select Upload Documents);*
Phone: 888-238-4840; Fax: 844-449-2553; **Voya Life Claims:** PO Box 1548, Minneapolis, MN 55440
Overnight Address: 250 Marquette Ave., Suite 900, Minneapolis, MN 55401

CLAIM CHECKLIST

☐ SIGN and DATE this completed form, then submit using one of the above methods.
☐ The **Attending Physician's Statement of Disability** must be completed and signed by the Attending Physician and submitted with this form.

SECTION 1. GROUP INFORMATION *(This information can be obtained from the Employer.)*

Group Name _____

Group Policy Number _____ Account Number _____

Claim Number *(if available)* _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

Select, if applicable.: ☐ International / Foreign Address

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____ Email _____

Phone (_____)_____ International Phone _____

SECTION 3. INSURED STATEMENT *(Use separate document to provide additional information if needed.)*

Describe Condition or Illness _____

_____

_____

Attending Physician Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Phone (_____)_____ Email _____

Cause _____

Other Attending Physician Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Phone (_____)_____ Email _____

Cause _____

Order #171891 (e) 03/01/2023

Group Policy Number _____

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

SECTION 3. INSURED STATEMENT *(Continued)*

Date You Last Worked _____ Date You Became Totally Disabled _____

Are you receiving any other disability benefits? . . . . . ☐ Yes ☐ No

If "yes," what type? _____

Are you house confined? . . . . . ☐ Yes ☐ No

Are you bed confined? . . . . . ☐ Yes ☐ No

Are you receiving any wages or salary? . . . . . ☐ Yes ☐ No

If "yes," what type? _____

Have you returned to work? . . . . . ☐ Yes ☐ No

If "yes," on what date? _____

Do you expect to return to work? . . . . . ☐ Yes ☐ No

If "yes," on what date? _____

SECTION 4. EDUCATIONAL BACKGROUND *(Select the highest grade completed.)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ AA ☐ AS ☐ BA ☐ BS ☐ MA ☐ Ph.D ☐ Other _____

SECTION 5. AUTHORIZATION AND ACKNOWLEDGMENT

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, LLC (MIB), Social Security Administration or employer to give the Company or its agents, employees and authorized representatives acting on its behalf (including ChoicePoint or any consumer reporting agency), ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information, as they apply to me. I give my permission to the Company to get consumer or investigative consumer reports about me.

I give my permission to the Company to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations -- 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between the Company and its affiliates and may be sent to MIB. This information may be made available to any Company affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with the Company or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given the Company's Consumer Privacy Notice and Insurance Information Practices Notice.

I hereby certify that the statements on this form are complete and accurate to the best of my knowledge.

New York Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

By typing your name in the box below, you are electronically signing this document. Your electronic signature will be legally binding and enforceable and the legal equivalent of your handwritten signature.

Employee / Insured Signature _____ Date _____

FRAUD WARNINGS

Alaska, Alabama, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESET FORM

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Submit at voya.com/claims *(select Upload Documents);*
Phone: 888-238-4840; Fax: 844-449-2553
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440
Overnight Address: 250 Marquette Ave., Suite 900, Minneapolis, MN 55401

The patient is responsible for the completion of this form without expense to the insurance company.

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ The Employee / Insured must complete Sections 1 and 2.
- ☐ The Attending Physician must complete Sections 3 - 11. ***** Include copies of patient's most recent office visit notes. *****

SECTION 1. GROUP OR POLICY INFORMATION

Group or Association Name [1] *(If applicable)* _____

Group or Association Policy Number [1] _____ **OR** Insurance Policy Number (s) _____

Claim Number *(if available)* _____

[1] ***Group or Association Name*** *and* ***Group or Association Policy Number*** *apply ONLY if coverage was obtained through an Employer or Association.*

SECTION 2. INSURED/PATIENT INFORMATION

Select, if applicable.: ☐ International / Foreign Address

Patient Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date _____ SSN _____

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____ Email _____

Phone (_____) _____ International Phone _____

SECTION 3. PRESENT CONDITION

When did symptoms first appear or accident happen? _____

Date you advised patient to cease work because of disability. _____

Has patient ever had the same or similar condition? ☐ Yes ☐ No *(If "yes," provide the date and description.)* _____

Subjective Symptoms _____

Objective Findings *(Provide results of current X-rays, EKGs or any other special tests.)* _____

Patient is: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

Diagnosis ICD-10 Code(s) _____

SECTION 4. TREATMENT AND PROGRESS *(Include copies of the most recent office visit notes.)*

Date of First Visit _____ Date of Last Visit _____ When did you last examine the patient? _____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other _____

Describe Patient Progress: ☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

Group Number _____ Policy Number _____

Patient Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

SECTION 5. EXTENT OF DISABILITY

Please describe the nature of any medical impairments (i.e., loss of function): _____

_____

Description of corresponding symptoms: _____

_____

Please describe the patient's cognitive and/or physical restrictions and limitations related to their disabling condition: _____

_____

Remarks: _____

_____

SECTION 6. MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds? . . . . . ☐ Yes ☐ No

SECTION 7. CARDIAC FUNCTIONAL CAPACITY *(Complete this section IF disability is due to Cardiac Condition.)*

American Heart Association Classification:

☐ Class 1 *(no limitation)* ☐ Class 2 *(slight limitation)* ☐ Class 3 *(marked limitation)* ☐ Class 4 *(complete limitation)*

Blood Pressure _____

SECTION 8. VISUAL IMPAIRMENT *(Complete this section IF disability is due to Visual Impairment.)*

What was vision at last observation? *(Snellen Notation)*

With Glasses: O.D. _____ O.S. _____ Date *(mm/dd/yyyy)* _____

Without Glasses: O.D. _____ O.S. _____ Date *(mm/dd/yyyy)* _____

Date corrected vision was irrecoverably reduced to 20/200 or less in the better eye _____ ☐ O.D. ☐ O.S.

Vision can be restored in whole or in part by:

O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

SECTION 9 PHYSICAL CAPACITIES EVALUATION

Functional Capacity: This is your estimate of your patient's functional capacity based on your knowledge of the patient. This information is important to assess your patient's eligibility for disability benefits.

Patient's ability to: (*Please check*)

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Walk	☐	☐	☐	☐

Patient's ability to perform: (*Please check*)

	Never 0%		Occasionally 1-33%		Frequently 34-66%		Continuously 67-100%	
	R	L	R	L	R	L	R	L
Fine Finger Movements	☐	☐	☐	☐	☐	☐	☐	☐
Hand/eye coordinated movements	☐	☐	☐	☐	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐	☐	☐	☐

Dominant Hand ☐ Right ☐ Left

Patient's ability to: (*Please check*)

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	☐	☐	☐	☐
Twist/bend/stoop	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate heavy machinery	☐	☐	☐	☐

Patient's ability to lift/carry: (*Please check*)

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐

SECTION 10. REMARKS

Group Number _____ Policy Number _____

Patient Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

SECTION 11. PHYSICIAN INFORMATION AND SIGNATURE

New York Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Attending Physician Name _____ Degree _____

TIN _____ Phone (_____)_____ Fax (_____)_____

Email _____

Address _____

City _____ State _____ ZIP _____

Attending Physician Signature _____ Date _____

FRAUD WARNINGS

Alaska, Alabama, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESET FORM

WAIVER OF PREMIUM DISABILITY CLAIM - EMPLOYEE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Submit at voya.com/claims *(select Upload Documents);*
Phone: 888-238-4840; Fax: 844-449-2553; **Voya Life Claims:** PO Box 1548, Minneapolis, MN 55440
Overnight Address: 250 Marquette Ave., Suite 900, Minneapolis, MN 55401

CLAIM CHECKLIST

☐ SIGN and DATE this completed form, then submit using one of the above methods.
☐ The **Attending Physician's Statement of Disability** must be completed and signed by the Attending Physician and submitted with this form.

SECTION 1. GROUP INFORMATION *(This information can be obtained from the Employer.)*

Group Name _____

Group Policy Number _____ Account Number _____

Claim Number *(if available)* _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

Select, if applicable.: ☐ International / Foreign Address

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____ Email _____

Phone (_____)_____ International Phone _____

SECTION 3. INSURED STATEMENT *(Use separate document to provide additional information if needed.)*

Describe Condition or Illness _____

_____

_____

Attending Physician Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Phone (_____)_____ Email _____

Cause _____

Other Attending Physician Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Phone (_____)_____ Email _____

Cause _____

Order #171891 (e) 03/01/2023

Group Policy Number _____

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

SECTION 3. INSURED STATEMENT *(Continued)*

Date You Last Worked _____ Date You Became Totally Disabled _____

Are you receiving any other disability benefits? . . . . . ☐ Yes ☐ No

If "yes," what type? _____

Are you house confined? . . . . . ☐ Yes ☐ No

Are you bed confined? . . . . . ☐ Yes ☐ No

Are you receiving any wages or salary? . . . . . ☐ Yes ☐ No

If "yes," what type? _____

Have you returned to work? . . . . . ☐ Yes ☐ No

If "yes," on what date? _____

Do you expect to return to work? . . . . . ☐ Yes ☐ No

If "yes," on what date? _____

SECTION 4. EDUCATIONAL BACKGROUND *(Select the highest grade completed.)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ AA ☐ AS ☐ BA ☐ BS ☐ MA ☐ Ph.D ☐ Other _____

SECTION 5. AUTHORIZATION AND ACKNOWLEDGMENT

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, LLC (MIB), Social Security Administration or employer to give the Company or its agents, employees and authorized representatives acting on its behalf (including ChoicePoint or any consumer reporting agency), ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information, as they apply to me. I give my permission to the Company to get consumer or investigative consumer reports about me.

I give my permission to the Company to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations -- 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between the Company and its affiliates and may be sent to MIB. This information may be made available to any Company affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with the Company or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given the Company's Consumer Privacy Notice and Insurance Information Practices Notice.

I hereby certify that the statements on this form are complete and accurate to the best of my knowledge.

New York Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

By typing your name in the box below, you are electronically signing this document. Your electronic signature will be legally binding and enforceable and the legal equivalent of your handwritten signature.

Employee / Insured Signature _____ Date _____

FRAUD WARNINGS

Alaska, Alabama, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

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New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures
For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices
Collecting Information
Your application or claim form is our main source of information. But we may:
- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, LLC., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, LLC." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports
Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use
We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure
We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, LLC, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information
If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, LLC.
We or our reinsurers may make brief reports to MIB, LLC (hereafter "MIB"). The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

53504

RETIREE DENTAL/VISION INSURANCE ENROLLMENT, CHANGE, OR CANCEL

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53504 (Rev. 12-2021)

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

PART A MEMBER INFORMATION

Member Name (Last, First, Middle)			NDPERS Member ID
Last Four Digits of Social Security Number			Date of Birth (mm/dd/yyyy)
Spouse Name (Last, First, Middle)			
Address	City	State	ZIP Code
Daytime Telephone Number			

PART B LEVEL OF COVERAGE

Both Insurance options below must be completed:

Dental Insurance Election: ☐ Retiree Only ☐ Retiree+Spouse ☐ Retiree+Child(ren) ☐ Retiree+Family ☐ **Decline**

Vision Insurance Election: ☐ Retiree Only ☐ Retiree+Spouse ☐ Retiree+Child(ren) ☐ Retiree+Family ☐ **Decline**

PART C EFFECTIVE DATE & REASON

Effective Date of Change (mm/dd/yyyy)

Change Reason

☐New Coverage (Select a Reason): ☐New Retiree ☐Medicare Eligible ☐Surviving Spouse
☐Marriage (Date of Marriage _____/_____/_____)
☐ Loss of Other Coverage (Attach a Certificate of Creditable Coverage)
☐Transfer from existing NDPERS policy. Current policyholder name & PERSLink ID: _____
☐Remove Dependent/Spouse
☐Add Dependent/Spouse: Is this an adult child? ☐No ☐Yes. Please answer the following questions.
Is adult child eligible to enroll under their own or spouse's employer insurance plan? ☐No ☐Yes
Is adult child disabled? ☐No ☐Yes

PART D DEPENDENT INFORMATION

List all family members to be covered under the plan, other than yourself:

a. Indicate dependent's address below name if address is different from yours.
b. Relationship: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
c. Marital Status: (S) Single, (M) Married, (D) Divorced, or (W) Widowed
d. If you are single and applying for family coverage, a copy of birth certificate for each Eligible Dependent is required.
e. If you are adding a grandchild, submit Grandchild Eligibility Verification SFN 60983 and 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.

Last Name	First Name	Middle Name	Relationship	Gender	Date of Birth	Marital Status	Social Security Number*
			Spouse				

PART E OTHER DENTAL OR VISION COVERAGE INFORMATION

Are you, your spouse or any of your Eligible Dependents currently or were previously covered by another insurance 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 eligibility.**

Other Coverage Name & Phone Number	Policy Number	Policyholder (Last, First, Middle)	Date of Birth	Policy Coverage Dates (mm/dd/yyyy)	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

If no, why?

Workers' Compensation/No-Fault

Are you, your spouse or any Eligible Dependents currently receiving or have received worker's compensation benefits? ☐No ☐Yes
Are you, your spouse or any Eligible Dependents currently receiving no-fault benefits? ☐No ☐Yes

PART F PAYMENT METHOD

If you are drawing a pension from a NDPERS defined benefit plan (NDPERS/NDHPRS), the Teacher's Fund for Retirement (TFFR), or the Job Service Retirement Plan, your insurance premium(s) may be deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.

If you are drawing a pension from TIAA or the NDPERS Defined Contribution Plan or you are an ex-legislator, your insurance premium(s) must be withheld from a bank account and SFN 50134 must be completed.

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written cancellation request must be submitted by the end of the month prior to the effective date. The cancellation request must include the member's name, NDPERS member ID, last four digits of social security number, and effective date. Partial month or retroactive cancellations will not be accepted.

RETIREMENT GROUP	PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS ☐ TFFR ☐ Job Service ☐ TIAA ☐ NDPERS Defined Contribution ☐ Ex-Legislator ☐ Alternate Retirement System	☐ Deduct from Pension Check (NDPERS/NDHPRS, TFFR, or Job Service only) ☐ Withhold from Bank Account (Complete SFN 50134)

PART G MEMBER AUTHORIZATION

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. If canceling coverage, I understand I will be responsible to request reimbursement from RHIC vendor for my retiree health insurance credit, if any.

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.

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

50134

AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 50134 (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)

PART B MEMBER AUTHORIZATION

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.

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 ☐☐☐☐☐☐☐☐☐
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.

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 will deduct these premiums to the point you authorize. 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. 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 you want to begin your premium deduction

CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53512 (Rev. 09-2021)

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/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)

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.