(Rev. 03-2022)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

TRANSFER FORMS CHECKLIST

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53706

NOTICE OF TRANSFER

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53706 (Rev. 05-2023)

Clear Form

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

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 CURRENT EMPLOYER

Organization Name		NDPERS Organization ID
Last Date of Service with Current Agency	Date of Last Regular Paycheck	Last Month of Reported Retirement Contributions
Last Month Insurance Premium(s) paid by your agency/or this employee (mm/yyyy)	Projected Hours of Sick Leave To Date of Transfer (must complete SFN 53404 to "bank" rejected hours)	

PART C CURRENT PLAN INFORMATION (Check yes or no for all NDPERS plans the employee is currently participating in)

Defined Benefit Plan	☐No ☐Yes	
Defined Contribution Plan	☐No ☐Yes	
☐Deferred Comp (457) ☐Other 457/403(b)	☐No ☐Yes	
	If Yes, Provider(s) If more than one provider, attach a detailed memo	If Yes, Monthly Deduction $
Group Health Insurance	☐No ☐Yes, select ☐Single ☐Family ☐PPO ☐HDHP	
Group Life Insurance	☐No ☐Yes, select	☐$12,000 Basic Life ☐Supplemental $_____.00 ☐Dependent $_____.00 ☐Spouse Supplemental $_____.00
Group Dental Insurance	☐No ☐Yes, select	☐Individual Only ☐Individual & Spouse ☐Individual & Child(ren) ☐Family
Group Vision Insurance	☐No ☐Yes, select	☐Individual Only ☐Individual & Spouse ☐Individual & Child(ren) ☐Family
FlexComp Plan	☐No ☐Yes	
	☐If Yes, Medical Spending Annual Deduction $	☐If Yes, Dependent Care Annual Deduction $

PART D AUTHORIZATION OF CURRENT AUTHORIZED AGENT

I certify that the above information is true and correct.

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

PART E NEW EMPLOYER

Organization Name	NDPERS Organization ID
First Day of Service with New Agency	Date of First Regular Paycheck
New Job Classification ☐Classified State ☐Non-Classified State ☐Non-State ☐State University System ☐TIAA ☐NDTFFR ☐Judge ☐Peace Officer ☐Correctional Officer ☐Firefighter ☐Elected Official ☐Appointed Official	
Employment Type ☐Permanent ☐Temporary	Status ☐Contributing ☐Non-Contributing
Seasonal ☐6 Months ☐9 Months ☐10 Months ☐11 Months	Hourly ☐No ☐Yes

PART F AUTHORIZATION OF NEW AUTHORIZED AGENT

I certify that the above information is true and correct.

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

INSTRUCTIONS

Often employees will terminate their position with an employer participating in NDPERS and take a job with another employer who is also participating in NDPERS. Therefore, the employee's membership is transferred to the new employer and membership IS NOT terminated unless the new employer does not offer or is not eligible for a particular NDPERS plan.

PART A MEMBER INFORMATION

For member identification, please provide all requested information.

PART B CURRENT EMPLOYER

An NDPERS Transfer Guide and Forms must be given to the employee to complete. **Completed forms must accompany the Notice of Transfer SFN 53706.**

Indicate the current employer's name and NDPERS assigned organization ID. Indicate the last day of employment, the last regular paycheck issued to the employee, and the last month retirement contributions will be reported.

Indicate last month insurance premiums will be paid by your agency/employee.

Indicate the projected accumulated unused sick leave at the date of transfer.

PART C CURRENT PLAN INFORMATION

Check the appropriate box on the right side for all NDPERS plans. If the employee does not participate in a plan, check the NO box. If the employee does currently participate, check the YES box and complete all applicable boxes following, if any.

PART D AUTHORIZATION OF AUTHORIZED AGENT

The current agency's designated NDPERS authorized agent must sign and date this form.

PART E NEW EMPLOYER

This form should be forwarded to the new employer. The new employer should indicate the organization name and NDPERS ID; as well as the first day of employment and the employee's first regular paycheck.

The new employer should transfer any eligible plan participation as indicated in Part C with NO change in the levels of coverage.

Any plans the employee currently participates in but not offered or eligible through new employment will be terminated.

Any plans the employee currently does not participate in but now is offered or eligible through new employment, the employer must enroll as a new employee. See your NDPERS Employer's Guide for instructions for enrolling a new employee.

PART F AUTHORIZATION OF AUTHORIZED AGENT

The new agency's designated NDPERS authorized agent must sign and date this form.

TRANSFER OF UNUSED SICK LEAVE VERIFICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53404 (Rev. 08-2021)

Clear Form

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(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)

PART B MEMBER AUTHORIZATION

I authorize the exchange of unused sick leave information between my Former Employer, New Employer, and the North Dakota Public Employees Retirement System.

I understand that a completed "Transfer of Unused Sick Leave Verification SFN 53404" MUST be on file at NDPERS **within 60 days from the date I leave employment with my former employer**.]

I understand that if I fail to submit this form to NDPERS upon employment transfer **within the 60 days**, any unused sick leave accumulated with my previous employer will be forfeited. I will no longer be eligible to purchase these unused sick leave hours and convert to service credit at a later date when I terminate NDPERS employment.

I understand that upon my termination of employment, I will have the opportunity to convert my unused sick leave to service credit according the North Dakota Administrative Code Chapter 71-02-03-06.

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

PART C FORMER EMPLOYER VERIFICATION

Organization Name	NDPERS Organization ID
Total number of hours of unused sick leave at time of employment transfer	
Signature of Authorized Agent (Electronic Signatures will not be accepted)	Date of Signature

PART D NEW EMPLOYER VERIFICATION

Organization Name		NDPERS Organization ID
Total number of hours of unused sick leave **accepted**	Total number of hours of unused sick leave **rejected**	
Signature of Authorized Agent (Electronic Signatures will not be accepted)		Date of Signature

INSTRUCTIONS

PART A MEMBER INFORMATION

For member identification, please provide all requested information.

PART B MEMBER AUTHORIZATION

Member must read authorization, provide signature and date. This will authorize the information to be exchanged between employers and NDPERS. Once signed, member should forward the form to their former employer for completion.

PART C FORMER EMPLOYER VERIFICATION

Member's former employer must complete all information requested in Part C for the section to be valid. Once completed, former employer should forward the form to the new employer for completion.

PART D NEW EMPLOYER VERIFICATION

Member's new employer must complete all information requested in Part D for the section to be valid. Once sections A-D are completed, the form should be forwarded to NDPERS for processing. Upon receipt of a valid form at NDPERS, the hours of unused sick leave rejected by the new employer will be entered into the PERSLink system. Only documented hours at NDPERS will be eligible for purchase, along with any additional accumulated sick leave hours, when the member terminates eligible NDPERS employment at a future date.

60036

HEALTH INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 60036 (Rev. 09-2022)

Clear Form

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

PART A MEMBER IDENTIFICATION

Employee Name (Last, First, Middle)		NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)	Daytime Telephone Number
Organization Name		NDPERS Organization ID
Preferred Email Address	Active in the Military ☐No ☐Yes	

PART B INSURANCE ELECTION

Date of Change (mm/dd/yyyy) - Actual effective date of coverage will be determined by NDPERS based on plan provisions.

Section 1 Reason for Change

☐New Coverage (I do not have existing coverage)
☐Annual Enrollment
☐ACA Temporary **(Employer Complete Part F)**
☐Cancel Coverage
☐Loss of Other Coverage (Attach a Certificate of Creditable Coverage)

☐Transfer Employment

From	To

☐Transfer from existing NDPERS policy. Current policyholder name & PERSLink ID: _____
☐ Return from Leave of Absence (LOA)

☐Remove Dependent
☐Add Dependent/Spouse: Is this an adult child? ☐No ☐Yes If yes, please answer the following question.
Is adult child Disabled? ☐No ☐Yes If yes, complete SFN 58556 and SFN 58798.

Section 2 Type of Coverage (Choose ONE option)

☐**PPO/Basic Health Plan**

PPO/Basic Health Plan Authorization: By signing this application I represent that I am joining the PPO/Basic Health Plan. I acknowledge I have had the opportunity to review the terms and conditions relating to participation in the PPO/Basic Health Plan.

☐**High Deductible Health Plan/Health Savings Account (HDHP/HSA)** This option is available only to permanent employees of state agencies, the university system, and district health units.

HDHP/HSA Authorization: By signing this application I represent that: (1) I am joining a HDHP/HSA; (2) I will not be covered by any other health plan that is not a HDHP (including my spouse's general-purpose health care Flexible Spending Account, which is a non-HDHP) for the upcoming plan year or enrolled in Medicare; I have not enrolled in my employers general-purpose health care Flexible Spending Account for the upcoming plan year and (3) I cannot be claimed as a dependent on another person's tax return. I understand that a HSA will be established on my behalf. I acknowledge I have had an opportunity to review the terms and conditions relating to participation in the HDHP/HSA.

Would you like to contribute to an HSA on a pre-tax basis? ☐No ☐Yes

Health Savings Account (HSA) Annual Maximum:

	2022	2023
Single HDHP Coverage:	$3,650	$3,850
Family HDHP Coverage:	$7,300	$7,750
Age 55+ Catchup:	$1,000	$1,000

HDHP/HSA election continued on the next page

The HSA limits include all contributions (both employee & employer paid) for the calendar year. I understand that If I exceed the annual limits, it will be my responsibility to request a refund from the HSA administrator or be subject to federal excise tax.

If my employer allows pre-tax payroll deductions to my Health Savings Account, I elect to defer a monthly amount of: $

I understand that I may modify my election at any time throughout the year as long as applicable payroll timelines are followed.

I understand that if I am joining the HDHP due to annual enrollment and currently participate in my employer's Flex Medical Spending Account (MSA), my deduction to my HSA will begin no sooner than February and may be delayed until April if my MSA is not exhausted as of December 31. I also understand that if this is the case, the amount I may defer annually to my HSA will be prorated based on the limits and the number of months eligible.

Section 2 Signature for the HDHP/HSA Plan

Member's Signature for the HDHP/HSA Plan (Electronic signature is not accepted)	Date of Signature

Section 3 Level Of Coverage for Plan

☐ Single Coverage (Self Only)
☐ Family Coverage (Self and Spouse OR Self and Eligible Child(ren) OR Self, Spouse, Eligible Child(ren)

PART C 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. 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.

*If the social security number is unknown at time of application, you may still submit the application, but will need to follow-up with this information once received/known.

Dependent Name (last, first, middle) If address is different than subscriber, indicate address under name	Relationship	Gender	Date of Birth	Social Security Number	Marital Status	Court Ordered Coverage	
						No	Yes
	Spouse					N/A	
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

Continue to page 3

PART D

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 - Explain why:

PART E EMPLOYER CERTIFICATION OF ACA ELIGIBLE TEMPORARY EMPLOYEE

I certify that this employee meets the definition of a full-time employee under the Affordable Care Act and as such, is being offered coverage.

Check appropriate method of determination

☐ **Monthly Measurement**

☐ Date of New Hire (mm/dd/yyyy)	☐ Date of Change in Position/Increase in Hours (mm/dd/yyyy)

☐ **Look-back Measurement**

The current measurement period used by the employer is

From	To

This information is required for NDPERS to determine enrollment eligibility.

Authorized Agent's Signature (Electronic signature is not accepted)	Date of Signature

Member Authorization on next page

PART G MEMBER AUTHORIZATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (front and back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively cancelling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

- I understand members are subject to limitations and exclusions outlined in the relevant Benefit Plan/Policy.
- I understand that in the event the group through which I am enrolled elects to terminate, the Insurance Carrier has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.
- I understand conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with the Insurance Carrier and has enrolled as a group with another Insurance Carrier.
- I understand, in the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit to NDPERS.
- I acknowledge that the Summary of Benefits and Coverage and other related plan information is available on the NDPERS website at https://www.ndpers.nd.gov/.

Please retain a copy of this Application for your records

Member's Signature (Electronic signature is not accepted)	Date of Signature

14120

CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 14120 (Rev. 08-2021)

Clear Form

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

PART A APPLICANT INFORMATION

Name (Last, First, Middle)	Applicant's NDPERS Member ID	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 ☐ Cancel COBRA ☐ Remove Dependent
☐ Divorce from current contract holder ☐ Attained Age 26 ☐ ACA ineligibility **Date of Event**
☐ Death of current contract holder ☐ Contract holder entitled to Medicare

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 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

DENTAL/VISION INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58792 (Rev. 12-2021)

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PART A MEMBER IDENTIFICATION

Employee Name (Last, First, Middle)		NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth	Daytime Telephone Number
Organization Name		NDPERS Organization ID

Active in the Military?
☐No ☐Yes

PART B INSURANCE ELECTION

Date Of Change (mm/dd/yyyy)

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

Section 1 Reason for Change

☐New Coverage (I do not have existing coverage)
☐Annual Enrollment
☐Cancel Dental Coverage
☐Cancel Vision Coverage
☐Remove Dependent
☐Loss of Other Coverage
☐Transfer Employment:
from _____ to _____
☐Transfer from existing policy **(Complete Part D)**

☐Add Dependent: Is this an adult child? ☐No ☐Yes, Please answer the following question.
Is adult child Disabled? ☐No ☐Yes

Section 2 Level Of Coverage for Plan(s):

Dental Insurance	**Vision Insurance**
☐Single Coverage	☐Single Coverage
☐Employee and Spouse	☐Employee and Spouse
☐Employee and Child(ren)	☐Employee and Child(ren)
☐Employee and Family	☐Employee and Family

Section 3 Pre-Tax Payroll Deduction Election

Do not complete Section 3 if you are an employee with Higher Education or a District Health Unit that does not participate in the NDPERS FlexComp plan.

Your insurance premium can be a pre-tax payroll deduction. If you pre-tax an insurance premium, you may not change coverage during the plan year unless you experience an IRS Qualified Change of Status.

Do you wish to have your insurance premium deducted as a pre-tax payroll deduction? Dental Insurance ☐ No ☐ Yes
Vision Insurance ☐ No ☐ Yes

Continued

PART C DEPENDENT INFORMATION

1. List all family members to be covered under the plan **indicated in Part B, Section 2**, 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
2. 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.

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.

Dependent Name (last, first, middle) If address is different than subscriber, indicate address under name	Relationship	Gender	Date of Birth	Social Security Number	Marital Status	Court Ordered Coverage	Active Military
	Spouse					N/A	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes

PART D 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 attach Certificate(s) of Coverage or other documentation from your insurance company. Failure to provide documentation may affect your eligibility.**

Plan**	Other Coverage Name & Phone Number	Policy Number	Policyholder (last, first, middle)	Date of Birth	Policy Coverage Dates (mm-dd-yy)	Name(s) of Person(s) Covered
					From: To:	
					From: To:	

****For Plan, indicate type of coverage -- Dental, or Vision**

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

Person's Name	Injury Date (MM-DD-YY)	Type of Injury	Company Providing Benefits & Phone Number

Continued

PART E MEMBER AUTHORIZATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I understand that by making this election, I will be required to participate in the plan for the current calendar year and may only be able to cancel coverage during a future annual enrollment or upon termination of my employment.

I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (front and back pages) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively cancelling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

- I understand members are subject to limitations and exclusions outlined in the relevant Benefit Plan/Policy.
- I understand that in the event the group through which I am enrolled elects to terminate, the Insurance Carrier has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.
- I understand conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with the Insurance Carrier and has enrolled as a group with another Insurance Carrier.
- I understand, in the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit to NDPERS.
- I acknowledge that the Summary of Benefits and coverage and other related plan information is available on the NDPERS website at ndpers.nd.gov.

Please retain a copy of this Application for your records

_____ _____

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

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AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 50134 (Rev. 08-2021)

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(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

LIFE INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53803 (Rev. 10-2021)

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

Underwritten by Voya Financial (Carrier) Policy Number: 67389-7

PART A EMPLOYER/EMPLOYMENT STATUS

Organization Name	NDPERS Organization ID	Employment Status ☐ Active Full-Time ☐ Active Part-Time

This Change is due to: (Check all that apply)

☐ New Hire (Date of Hire_____/_____/_____)
☐ Annual Enrollment-Read below for Evidence of Insurability (EOI) requirements
☐ Decrease Coverage ☐ Marital Status Change (Date of Change _____/_____/_____)
☐ Birth/Adoption (Date of Change_____/_____/_____)

Effective Date

_____/01/20____

PART B EMPLOYEE INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last 4 Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Personal Email Address	Telephone Number

PART C EMPLOYEE COVERAGE

Basic Life ☒ Employee Only—Employer Provides $7,000 of Basic Life Coverage at no expense to you
(Temporary employees electing coverage are responsible for basic life premium)

Supplemental Life and AD&D Election: When you are first eligible for supplemental life coverage, you can elect up to the Guaranteed Issue (GI) Limit of $200,000 without evidence of insurability (EOI). You can request coverage above the GI Limit to a maximum of $400,000, but must submit EOI. You are subject to approval by the carrier for the amount above GI. During annual enrollment, you can increase your existing employee supplemental by up to a $25,000 increment without EOI up to the GI Limit. EOI must be completed for newly electing employee supplemental (only have Basic $7,000), increases larger than $25,000, or requests above the GI Limit and are subject to approval by the Carrier.

☐ I am applying for a TOTAL (include Basic Life in total) supplemental life coverage of $_____ (Increments of $5,000)
☐ Waive Additional Supplemental Life & AD&D coverage

PART D DEPENDENT COVERAGE

Supplemental Dependent Life Insurance Election: Only available if you elected Supplemental in Part C. When you are initially eligible for dependent coverage or during annual enrollment, you can elect it without providing evidence of insurability.

☐ $10,000 for eligible spouse and $10,000 for each eligible dependent child. **OR**
☐ $7,000 for eligible spouse and $7,000 for each eligible dependent child. **OR**
☐ $5,000 for eligible spouse and $5,000 for each eligible dependent child. **OR**
☐ $2,000 for eligible spouse and $2,000 for each eligible dependent child.
☐ Waive Supplemental Dependent Coverage

PART E SPOUSE COVERAGE

Supplemental Spouse Life Election: Only available if you elected dependent coverage in Part D. When you are initially eligible for supplemental spouse coverage, you can elect up to $50,000 in coverage without providing evidence of insurability. Total spouse coverage up to $200,000 is available if your spouse completes an Evidence of Insurability form (EOI) for approval by the Carrier. **Supplemental spouse coverage is limited to 50% of the employee's coverage amount.** Upon a qualifying event or annual enrollment, an Evidence of Insurability form (EOI) must be completed.

☐ **Total Amount of coverage** $_____ (Increments of $5,000)

Name	**Date of Birth(mm/dd/yyyy)**

☐ Waive Supplemental Spouse Coverage

PART F BENEFICIARY INFORMATION

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855

Part G AUTHORIZATION AND INSTRUCTIONS

I acknowledge I have read the authorization on page 2 of SFN 53803.

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

PART G AUTHORIZATION

READ THIS INFORMATION CAREFULLY AND SIGN THIS FORM ON PAGE 1 BEFORE SUBMITTING IT TO NDPERS.

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- 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, provided I am actively at work.
- I understand that evidence of insurability may be required for coverage to become effective.

INSTRUCTIONS

Part A Employer/Employment Status

Must be completed by your employer's authorized agent.

Part B Employee Information

For member identification, please provide all requested information.

Part C Employee Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have 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 or elect to decrease your level of coverage. Indicate the TOTAL amount of coverage you are requesting.

Part D Dependent Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have 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 or elect to decrease your level of coverage.

Part E Spouse Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have 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 or elect to decrease your level of coverage.

Part F Beneficiary Information

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855.
IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part G Authorization

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

EVIDENCE OF INSURABILITY (EOI)
When you need more Life Insurance.

Instructions **NDPERS** 67389-7

By completing the Evidence of Insurability (EOI) form, you are providing the additional information needed to review your request. Any Guaranteed Issue amount available to you will be provided regardless of your EOI application.

1. **Getting Started:**
   - Know how much insurance you need.
   - Know how much insurance you already have through your employer, what type of insurance it is, and how much you are eligible for.
   - Know your/your spouse's primary health practitioner contact info.

2. **Completing the EOI:**
   - Complete **all** sections of this form. Ignore **OPTIONS** section. (ING use only)
     - The privacy and security of your personal contact and health information is critically important to us.
     - We will not share your information with your employer or anyone not directly involved in the underwriting process per attached privacy statement.
   - Sign & Date this form.
     - Your signature is required.
     - Your spouse's signature is only required if applying for spouse coverage.

3. **Submitting your EOI Application:**
   - Make a copy of your EOI form for your records.
   - Return your completed EOI form to your Payroll/HR Office for forwarding to NDPERS.

4. **Questions:**
   - Contact your Payroll/HR Office to verify your current amount of coverage or any Guaranteed Issue amount you may be eligible for.
   - Call Medical Underwriting at1-800-537-5024, Option 4 if you have questions on how to complete this form or the status of your submitted EOI.

FORM EXAMPLE AND DEFINITIONS

(A) This is the total amount of insurance protection you need, listed by type of insurance. (NOTE: Coverage available is dependent on the plan offered by your employer.)

(B) This is the amount that may be paid by your employer and/or is being deducted from your pay.

(C) This is the amount your plan allows you to have , during this enrollment, without completing the health questions on this form.

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
☑ Employee Basic Life	$ 150,000	$ 50,000	$ 50,000	$ 50,000
☑ Employee Supplemental Life	$ 500,000	$ 0	$ 100,000	$ 400,000
☑ Spouse Supplemental Life	$ 50,000	$ 10,000	$ 0	$ 40,000
☑ Children Supplemental Life (per child)	$ 10,000	$ 0	$ 0	$ 10,000

Use the check-boxes to choose the types of coverage.

If you don't have current coverage in force, just enter "0" here.

If your employer's plan does not guarantee minimum coverage for the insurance type, just enter "0" here.

Definitions:

Employee Basic Life Insurance is coverage your employer most often pays for.

Employee Supplemental Life insurance is typically paid for by the employee. It is often chosen as additional coverage when more insurance is needed.

Spouse Supplemental Life & Child Supplemental Life can be purchased as additional protection, if allowed by your plan. It is typically paid for by the employee.

RESET FORM

EVIDENCE OF INSURABILITY (ND)

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya family of companies
PO Box 20, Mail Stop 4-S, Minneapolis, MN 55440
Phone: 612.342.7262 Fax: 612.467.8721

VOYA FINANCIAL™

Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number **673897** Account Number **1** Employer Name **NDPERS**
Option 1 _____ Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female
SSN _____ Personal E-mail Address _____ Birth Date _____
Address _____ City _____ State _____ ZIP _____
Home Phone (_____)_____ Cell Phone (_____)_____
Hire Date _____ Salary $_____ Occupation _____
Primary Health Practitioner _____ Practitioner Phone (_____)_____
Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS *(Complete this table based only on the coverage you have through this plan.)*

Are you completing this form due to a Family Status Change *(Marriage, Divorce, Birth, Adoption, etc.)*? ☐ Yes ☐ No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
☐ Employee Supplemental Life	$	$	$	$
☐ Spouse Supplemental Life	$	$	$	$

C. SPOUSE INFORMATION

Spouse Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female
SSN _____ Personal E-mail Address _____ Birth Date _____
Home Phone (_____)_____ Cell Phone (_____)_____
☐ Same Primary Health Practitioner as Employee *(See information above.)*
Primary Health Practitioner _____ Practitioner Phone (_____)_____
Practitioner Address _____ City _____ State _____ ZIP _____

D. CHILD INFORMATION *(Availability of Child coverage is dependent on plan rules and may also be dependent on approved employee coverage. If more than 3 children, list information on additional sheet.)*

Name *(First, MI, Last)*	Birth Date	Gender	Relationship
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

Dependent Children Health Questions *(Answer these questions only if applying for dependent child(ren) coverage.)*

1. Within the past 5 years, have any dependent children been treated for or diagnosed with a mental or nervous disorder (excluding ADHD), diabetes, heart disorder, cancer, asthma (requiring hospitalization within the last 2 years), or chemical abuse? . . . . . ☐ Yes ☐ No
2. Do any dependent children have cerebral palsy, cystic fibrosis, muscular dystrophy, developmental disorder (including Autism and Down's Syndrome), or complications associated with premature birth? . . . . . ☐ Yes ☐ No

For each "Yes" answer, provide name(s) of child(ren) and details. _____

Employee Name _____ SSN *(Last 4 digits only.)* _____

E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS *(Must be answered for coverage that is not Guaranteed Issue.)*

Employee (EE) Yes	Employee (EE) No	Spouse (SP) Yes	Spouse (SP) No	
☐	☐	☐	☐	1. Have you ever been diagnosed or treated by a member of the medical profession as having AIDS, ARC, or the HIV infection?
☐	☐	☐	☐	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/ angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP. --->				3. **Employee:** Height _____ ft. _____ in. Weight _____ lbs. **Spouse:** Height _____ ft. _____ in. Weight _____ lbs.
				4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
☐	☐	☐	☐	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
☐	☐	☐	☐	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
☐	☐	☐	☐	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
☐	☐	☐	☐	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
☐	☐	☐	☐	e. Polycystic kidney disease or kidney failure?
				5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
☐	☐	☐	☐	a. Chest pain, heart trouble or circulatory disorder?
☐	☐	☐	☐	b. Anemia or leukemia?
☐	☐	☐	☐	c. Sleep apnea, asthma or other respiratory disorder?
☐	☐	☐	☐	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
☐	☐	☐	☐	e. Stomach disorder?
☐	☐	☐	☐	f. Brain or seizure disorder?
☐	☐	☐	☐	g. Mental or nervous disorder?
☐	☐	☐	☐	h. Arthritis, paralysis or any muscle weakness?
☐	☐	☐	☐	i. Abnormal urine specimen or urinary tract disorder?
☐	☐	☐	☐	j. Prostate or other reproductive organ disorder?
☐	☐	☐	☐	6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
☐	☐	☐	☐	7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
☐	☐	☐	☐	8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
☐	☐	☐	☐	9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

If applying for disability income coverage, please complete this additional question:

☐ ☐ - N/A - 10. In the past 5 years have you experienced symptoms of or been treated for arthritis, fibromyalgia, back or neck disorder, spinal disorder, joint or bone disorder, muscle disorder, carpal tunnel syndrome or chronic pain?

For every "Yes" answer, to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	

Employee Name _____ SSN *(Last 4 digits only.)* _____

F. AUTHORIZATION AND ACKNOWLEDGMENT *(Please read and sign below)*

For underwriting and claim purposes, I give my permission to any blood bank, blood center, plasma center, health care provider, any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described 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 permission 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 specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further 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 have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.
I declare that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

Return completed EOI to your payroll/HR Office for forwarding to NDPERS.

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, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." 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, 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, Inc.
We or our reinsurers may make brief reports to 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 (TTY 866 346-3642). 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.

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LIFE INSURANCE DESIGNATION OF BENEFICIARY

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53855 (Rev. 07-2021)

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)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	
Effective Date	

Policy Number
67389-7

PART B DESIGNATION OF BENEFICIARY

Primary Beneficiary(ies) If person enter Last, First, Middle	Relationship	Gender	Social Security Number	Birth Date	% Share	Address
					Total must equal 100%	

Contingent/Secondary Beneficiary(ies) If person enter Last, First, Middle	Relationship	Gender	Social Security Number	Birth Date	% Share	Address
					Total must equal 100%	

PART C MEMBER AUTHORIZATION

I understand that this election revokes any previous life insurance beneficiary designations. 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 Signatures will not be accepted)	Date

Part A Member Information

Enter your name, NDPERS ID number, date of birth, last four digits of your Social Security Number, marital status, and effective date of change.

Part B Designation of Beneficiary

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

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

3. If more than one person in a class (primary or contingent beneficiary) is named, members of that class will share equally in the benefits unless specific shares are designated. The total number of shares must equal 100 percent. The benefit will be distributed as directed by the designation. If a named beneficiary does not survive, the beneficiary’s share will be distributed among any surviving beneficiaries, in the same proportion as the initial shares.

4. To file a death claim, a certified copy of the Death Certificate must be provided to NDPERS to process the claim.

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

6. 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 C Member Authorization

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

CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53512 (Rev. 09-2021)

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

PART A PARTICIPANT/QUALIFIED BENEFICIARY INFORMATION

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

PART B CONTINUATION OF COVERAGE ELECTION / WAIVER

If you elect Medical Spending Continuation coverage, it will be in effect to the end of the current plan year, or December 31.

Do you wish to continue your current participation in the NDPERS Flexcomp Plan Medical Spending Account? ☐ Yes ☐ No

☐ I wish to pre-pay the premium through the end of the plan year with pre-tax dollars deducted from my final pay checks.

☐ I will pay the premium plus a 2% administration fee with after-tax dollars through the remainder of the plan year.

PART C AUTHORIZATION OF APPLICANT

I have read the information in its entirety, **including the back page**, and agree to abide by the terms of the Plan Document. I understand that if I have elected to pre-pay the premium from my final paychecks, that NDPERS will contact my employer to notify them of my election and to discuss termination processing. I certify, under penalties of perjury, that the information submitted on this form is true, correct and complete.

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

Entitlement to COBRA Coverage

Under provisions of the Internal Revenue Service (IRS) COBRA regulations, you have the opportunity to extend your participation in the Medical Spending Account to the end of the current plan year.

The employer has the responsibility to notify NDPERS of a participant's death, termination, or reduction in hours of employment.

Qualified Beneficiaries Your spouse or dependent(s) may elect to continue coverage in a medical spending account under the following circumstances:

1. Participant's death.
2. Divorce or legal separation.
3. A dependent child ceases to be a "dependent child" under the group health plan.

If you elect COBRA continuation, your premium payment will be based on the annual election amount in existence at the time of the qualifying event.

Under the law, it is the responsibility of the person seeking continuation coverage to inform NDPERS of a divorce, legal separation or a child losing dependent status within 60 days of the date of the event. If you are interested in COBRA continuation coverage, contact NDPERS for more information.

Length of COBRA Coverage

You, your spouse or dependent(s), are eligible to receive continuation coverage until the end of the plan year, or December 31, in which the qualifying event occurred. If you have paid your premium through the end of the year on December 31 and have a balance in your account, you have the option to have eligible expenses incurred during the "grace period", from January 1 through March 15 of the new plan year, reimbursed from that remaining balance. You will have until April 30 to submit claims. Any amount remaining in your medical spending reimbursement account after the April 30 claims filing deadline is forfeited.

COBRA Coverage Premiums

Employees who elect COBRA continuation coverage are permitted to pre-tax the COBRA premium and pre-pay the premium through the end of the current plan year from their final paychecks.
To pay the premium with after-tax dollars throughout the plan year, submit the premium amount plus a two percent (2%) administrative fee by the first of each month. If you fail to pay the premium on time, your coverage will terminate on the last day of the month for which a contribution was received.

Continuation coverage under COBRA is provided subject to your eligibility. NDPERS reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

You will have 60 days from the date of this notice to inform NDPERS that you want continuation coverage.

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS OF THE DATE OF THIS NOTICE YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE

3803

Clear Form

457 DEFERRED COMPENSATION PLAN ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 3803 (Rev. 12-2023)

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.

457 DEFERRED COMPENSATION PLAN QUICK ENROLLMENT/WAIVER

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 54362 (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 EMPLOYEE INFORMATION

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

PART B NDPERS COMPANION PLAN ENROLLMENT

I elect to enroll in the NDPERS Companion Plan. My enrollment automatically entitles me to maximize my retirement savings by vesting in the employer's contribution to the Defined Benefit Retirement Plan.

Choose one type of enrollment selection:

☐ $25 monthly (minimum enrollment amount) ☐ $_____ Per Pay Period (must be higher than the $25 monthly minimum)	Pay Period Beginning Date (Not Date Paid) mm/dd/yyyy

Terms of Agreement

- I understand that by electing to participate, my monthly salary will be reduced by the amount I have selected.
- I acknowledge my total monthly contribution will be divided, if applicable, to align with my employer's pay period schedule.
- I understand that by participating in the Companion Plan and the NDPERS Defined Benefit Retirement Plan, I am automatically enrolled in the Portability Enhancement Provision (PEP). Thus, the applicable employer contribution is redistributed to my NDPERS member retirement account as stated on the vesting schedule provided on this form.
- I acknowledge I have the right to increase or decrease the amount of contribution, change to another Provider company or suspend contributions at any time by completing the Participant Agreement for Salary Reduction - SFN 3803.
- I understand the accumulated deferred salary is not available to me until I separate from service, or when I experience an approved unforeseeable emergency. Early withdrawal of funds may incur in financial penalties.
- I acknowledge the NDPERS Board makes no recommendation as to any fund investment, and I understand the NDPERS Board does not warrant or guarantee the investment performance of the funds offered by any provider.
- I understand 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 authorize NDPERS to work with the North Dakota Office of Management and Budget if necessary to insure the appropriate amount is withheld from my paycheck.

I accept the Terms of Agreement, and I authorize my employer to deduct my Companion Plan contribution by my own designated amount on the Pay Period Beginning Date (Not Date Paid) listed above.

Member's Signature (Electronic Signature will not be accepted)	Date (Must be prior to Pay Period Beginning Date above)

PART C DECLINE ENROLLMENT IN NDPERS 457 DEFERRED COMPENSATION PLANS

I elect to decline enrollment in an NDPERS sponsored 457 Deferred Compensation Plan, including but not limited to the Companion Plan. I understand I will not maximize my retirement savings through vesting in the employer's contribution to the Defined Benefit Retirement Plan. I acknowledge I am eligible to begin participation in an NDPERS sponsored 457 Deferred Compensation Plan at a later date and by doing so, will proactively vest in the employer's contribution.

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

By electing to enroll in the Deferred Compensation Program through your employer at a minimum required monthly contribution of $25.00, you automatically enroll in the Portability Enhancement Provision (PEP) for the NDPERS Defined Benefit Retirement Plan. Your NDPERS retirement account will automatically be credited with the percentage of the employer contribution to which you are entitled based upon your years of credited service. As you attain additional service credit, you must increase your 457 contribution amount to the corresponding percentage of salary to achieve maximum vesting.

Service Credit	Minimum Contribution	Maximum Vesting %
0-12 Months	$25	1%
13-24 Months	$25	2%
25-36 Months	$25	3%
37+ Months	$25	4%

INSTRUCTIONS:

PART A EMPLOYEE INFORMATION

This form must be completed regardless of whether the employee elects to participate or declines to participate in the 457 Deferred Compensation Plan and Portability Enhancement Provision (PEP).

For member identification, please provide all requested information.

Part B QUICK ENROLLMENT IN DEFERRED COMP/PEP

This section should be completed if the employee elects to participate in the 457 Deferred Compensation Plan and the Portability Enhancement Provision (PEP). The employee's signature in this section **will authorize** a reduction in the employee monthly wage and contribution to a deferred compensation plan.

The employee must sign and date this section. **(This date must be in the month prior to the date entered above).**

Part C WAIVER OF PARTICIPATION

The employee must sign and date this section only if the **employee waives participation** in the Deferred Compensation Plan.