(Rev. 05-2024)

RETIREMENT CHECKLIST

RETIREMENT FORMS – Required for Benefit Payment		SFN #
☐	APPLICATION FOR MONTHLY RETIREMENT BENEFITS FOR DEFINED BENEFIT* APPLICATION FOR PERIODIC PAYMENTS FOR DEFINED CONTRIBUTION	2562 or 59045
☐	**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		
☐	APPLICATION FOR THE PARTIAL LUMP SUM OPTION – DEFINED BENEFIT (If at Normal Retirement Age)	54373
☐	APPLICATION FOR THE GRADUATED BENFIT OPTION – DEFINED BENEFIT (If at Normal Retirement Age)	59596
☐	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
☐	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

*Must be submitted prior to the last day of the month in which you terminate employment.

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APPLICATION FOR DEFINED BENEFIT PLAN MONTHLY PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 2562 (Rev. 12-2021)

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)
Home Email Address	Daytime Telephone Number

PART B APPLICATION FOR RETIREMENT BENEFITS

Last Date of Employment (mm / dd / yyyy): _____ / _____ /_____ *
Last Paycheck Date for Hours Worked (mm / dd / yyyy): _____ / _____ /_____*
* NDPERS will use these dates to determine your earliest eligible retirement date.

NDPERS Retirement Effective Date (mm /1/ yyyy): _____ / 1 /_____
(If you provide an ineligible date, NDPERS will use an effective date based upon your earliest eligibility.)

SECTION 1 Main System & Public Safety Retirement Only

☐ Main System Early Retirement (Age 55-64)	☐ Single Life
☐ Main System Normal Retirement (Rule OR Age 65+)	☐ 50% Joint Survivor/Life
☐ Public Safety Early Retirement (Age 50-55)	☐ 100% Joint Survivor/Life
☐ Public Safety Normal Retirement (Rule of 85 OR Age 55+)	☐ 10 Year Term Certain/Life
	☐ 20 Year Term Certain/Life

SECTION 2 Highway Patrol & Judges Retirement Only

☐ Highway Patrol Early Retirement (Age 50-55)	☐ Normal Retirement with 50% Joint Survivor/Life
☐ Highway Normal Retirement (Rule of 80 OR Age 55+)	☐ 100% Joint Survivor/Life
☐ Judges Early Retirement (Age 55-64)	☐ 10 Year Term Certain/Life
☐ Judges Normal Retirement (Rule of 85 OR Age 65+)	☐ 20 Year Term Certain/Life

PART C RETIREE HEALTH INSURANCE CREDIT (RHIC) - Required ALL Plans (except Main 2020)

Late applicants do not receive retroactive RHIC benefits

You must select one of the following:

☐ I elect the Standard RHIC option *(Default for Single member or Married member electing Joint Survivor Retirement above)*

☐ If Married and electing Single Life,10 or 20 Year Term Certain above, I elect the following actuarially reduced RHIC option: ☐ 50% Joint Survivor Life ☐ 100% Joint Survivor Life

PART D SICK LEAVE CONVERSION (Excluding Judges)

Do you wish to purchase all or part of your unused sick leave into retirement service credit? If Yes, the Conversion of Unused Sick Leave Application (SFN 58358) must be received prior to the last day of the month in which you either terminate or are no longer accruing sick leave.

☐ No ☐ Yes

PART E AUTHORIZATION

I elect to receive the NDPERS retirement benefits as indicated above. I understand I must submit a photocopy of my birth certificate. (If married, I must also submit a photocopy of spouse's birth certificate & marriage certificate.) This Application must be date stamped at NDPERS within 6 months of my retirement date and must be on file at least 30 days prior to the first retirement payment being issued. **Late applications will delay retirement effective date.**

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

Please refer to the "Group Retirement Plan" information sheet.

Part A Participant Identification

For member identification, please provide all requested information.

Part B Application for Retirement Benefits

Enter your last date of employment, last paycheck date, and the month and year you want your retirement benefits to begin. Your NDPERS retirement effective date will be the first of the month following your last date of service or last date of pay, whichever is later. Your actual payment is the month following your effective date.

Section 1: Complete if you participate in the Main System or Public Safety/Law Enforcement retirement plan.

- (left side) Indicate if you are an early retiree or a retiree meeting your normal retirement.
- (right side) Check your retirement payment option.

Section 2: Complete if you participate in the Highway Patrol or Judges Retirement plan.

- (left side) Indicate if you are an early retiree or a retiree meeting your normal retirement.
- (right side) Check your retirement payment option.

Once you elect your payment option and start drawing a pension, the election becomes irrevocable. The only exception is if your spouse passes away and you are drawing benefits under a Joint & Survivor/Life payment option.

Part C: Application for Retiree Health Insurance Credit (RHIC)

This is required to be completed for all plans with the exception of those enrolled in the Main 2020 plan.

Check your retiree health insurance credit option. You must make an election even though you may not be currently participating in the NDPERS group health insurance plan. If you are drawing a pension and are enrolled in any of the NDPERS retiree insurances (Dakota Plan, Dakota Retiree Plan, Dental and/or Vision) this retiree health insurance credit will be automatically be reimbursed for NDPERS premium(s).

Part D: Sick Leave Conversion

This section is to be completed ONLY if you participate in the Main System, Public Safety/Law Enforcement, and Highway Patrol retirement plan. Members of the Judges Retirement plan are not eligible to purchase unused sick leave.

Part E: Authorization

You must provide a legible photocopy of your birth certificate and if married, your spouse's birth certificate and marriage certificate.

YOU MUST SIGN AND DATE PART E TO VALIDATE THIS FORM

APPLICATION FOR DEFINED CONTRIBUTION PLAN PERIODIC PAYMENTS
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 59045 (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 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	
Daytime Telephone Number	

PART B APPLICATION FOR RETIREMENT BENEFITS & RETIREE HEALTH INSURANCE CREDITS

NDPERS Retirement Effective Date (mm/1/ yyyy): _____ / 1 /_____
(If you provide no date or an ineligible date, NDPERS will use an effective date based upon your earliest eligibility.)

SECTION 1 RETIREMENT PAYMENT OPTION

☒ Periodic Retirement Payment.

A TIAA Distribution Form MUST be completed and accompany this application.

SECTION 2 RETIREE HEALTH CREDIT OPTIONS (Check One)

☐ I elect the standard retiree health insurance credit option.

☐ If married I understand that I have the option to elect the following alternate actuarially reduced retiree health insurance credit option.

I elect (Check One)

☐ 50% Joint Survivor Life

☐ 100% Joint Survivor Life

PART C AUTHORIZATION

I elect to receive the retirement benefits and health insurance credit as indicated in PART B. 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 DEFINED CONTRIBUTION PLAN PERIODIC PAYMENTS SFN 59045" must be received by NDPERS at least 30 days before distribution of my first retirement payment.

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

Please refer to the "Group Retirement Plan" information sheet.

PART A PARTICIPANT IDENTIFICATION

For member identification, please provide all requested information.

PART B APPLICATION FOR RETIREMENT BENEFITS & RETIREE HEALTH INSURANCE CREDITS

Enter the month and year you want your retirement benefits to begin. Your NDPERS retirement effective date will be the first of the month following your last date of service or last date of pay, whichever is later. Your actual payment is the month following your effective date.

Section 1: This application is for periodic payments only. Your vested Account balance may be paid to you in monthly, quarterly, semiannual or annual periodic payments until your account is exhausted.

Section 2: Check your retiree health insurance credit option. You must make an election even though you may not be currently participating in the NDPERS group health insurance plan. This retiree health insurance credit can only be used if:

1. You participate in the NDPERS Dakota Plan (the NDPERS Group Health Insurance Plan),
2. You are drawing a periodic payment from the NDPERS Defined Contribution Plan, and
3. You are at least 55 years old or meet the Rule of 85.

PART C AUTHORIZATION

You must provide a legible photocopy of your birth certificate and if married, your spouse's birth certificate and marriage certificate.

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

58358

CONVERSION OF UNUSED SICK LEAVE APPLICATION– DEFINED BENEFIT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58358 (Rev. 01-2022)

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

PART A PARTICIPANT IDENTIFICATION

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

PART B NOTICE TO MEMBER

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

PART C HOURS OF UNUSED SICK LEAVE

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

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

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

PART D APPLICATION FOR AFTER TAX PAYMENT THROUGH PERSONAL CHECK

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

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

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

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

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

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

Signature of Authorized Agent	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.

54373

APPLICATION FOR THE PARTIAL LUMP SUM OPTION – DEFINED BENEFIT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 54373 (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

NOTE: This form is not an application for a lump sum refund/rollover of your retirement account balance; complete an Application for Refund or Direct Rollover SFN 53879.

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 NOTICE TO MEMBER

The Partial Lump Sum Option (PLSO) is NOT available to early and disabled retirees, or surviving spouses. The PLSO allows you to take a partial lump sum distribution equal to 12 monthly payments determined under the Single Life/Normal benefit option. (No variations will be accepted). If this option is elected, your monthly benefit will be actuarially reduced. You will still be permitted to choose one of the optional forms of payment for your ongoing monthly benefit with exception of the Graduated and Deferred Normal Retirement Options. In addition, the PLSO payment, as well as your ongoing monthly benefits, will be subtracted from your individual minimum guarantee.

This option is a once in a life time election and made at the time of your initial retirement. You may not make an election after receiving your first retirement check nor apply for a second PLSO upon subsequent reemployment and retirement. Please read the **"Special Tax Notice Regarding Plan Payments"** before continuing. Under Federal law, NDPERS is required to provide this information a minimum of 30 days prior to a distribution. This may affect the date of your PLSO payment.

PART C APPLICATION FOR PARTIAL LUMP SUM PAYMENT (PAID TO MEMBER)

1. ☐ Check this box if you wish to elect a lump sum payment payable to you minus 20% for Federal income tax.
2. Please indicate if you want NDPERS to withhold North Dakota State income tax. If you DO NOT indicate your preference, ND State income tax will be automatically withheld. After a lump sum payment is issued, any adjustments to Federal or State income tax paid is the responsibility of the taxpayer.
   Check One ☐Yes- Withhold North Dakota State Income Tax
   ☐No – DO NOT Withhold North Dakota State Income Tax

PART D APPLICATION FOR PARTIAL LUMP SUM PAYMENT (DIRECT ROLLOVER)

☐Check this box if you wish to have a direct rollover of your PLSO.
Please have a letter of acceptance forwarded to NDPERS from the financial institution. If any portion of your PLSO includes non-taxable income, then the letter of acceptance is required before your request will be processed.

Make Check Payable To (Rollover Institution)

Member's Account Number with Receiving Institution (If Available)

Mailing Address of Rollover Institution	City	State	ZIP Code

Portion to be rolled over: (If no election is indicated, NDPERS will automatically roll over 100% of your taxable income to your designated rollover institution and mail any non-taxable income directly to you).

☐All of my taxable income ☐All of my taxable & non-taxable income ☐____% of my Account

☐$_____of my Account

My NDPERS benefits are being rolled into **(Choose one. Required)**

☐Employer Sponsored Plan ☐ Traditional IRA ☐ Roth IRA

PART E AUTHORIZATION

I have reviewed and understand the above provisions, and hereby elect the Partial Lump Sum Option. I understand my election is irrevocable and that the Partial Lump Sum option is a once in a life-time election.

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

INSTRUCTIONS

PART A MEMBER INFORMATION

For member identification, please provide all requested information.

PART B NOTICE OF MEMBER

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

PART C APPLICATION FOR PARTIAL LUMP SUM PAYMENT (PAID TO MEMBER)

Complete this section to authorize a Partial Lump Sum Payment paid direct to you.

Payments are subject to Federal and ND State income tax. NDPERS is required to withhold Federal income tax; however, you may authorize NDPERS to withhold ND State income tax from your payment. If no preference is indicated, NDPERS will automatically withhold 3.92% of the taxable portion of your payment. After a payment is issued, any adjustments to Federal or State income tax paid will be your responsibility.

PART D APPLICATION FOR PARTIAL LUMP SUM PAYMENT (DIRECT ROLLOVER)

Complete this section to authorize a Partial Lump Sum Payment as a direct rollover.

1. Enter the name of the plan or rollover institution accepting the direct rollover **(i.e. who the check should be made payable to - who will endorse the check)**. Please have your plan or rollover institution forward a letter of acceptance of funds to NDPERS. If any portion of your rollover is non-taxable income, this will be required before your rollover is completed.
2. Enter your account number with the plan or rollover institution where your funds will be rolled over.
3. Enter the full mailing address to which the direct rollover payment should be mailed. **DO NOT LIST YOUR PERSONAL MAILING ADDRESS: NDPERS CAN NOT SEND A DIRECT ROLLOVER TO A MEMBER'S HOME.**
4. Indicate how much of the income should be directly rolled over. If no election is indicated, NDPERS will automatically roll over 100% of your taxable income to your designated rollover institution and mail any nontaxable income directly to you.
5. Check if your retirement fund is being rolled over into an employer sponsored plan, traditional IRA, or Roth IRA.

PART E AUTHORIZATION

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

59596

APPLICATION FOR THE GRADUATED BENEFIT OPTION – DEFINED BENEFIT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 59596 (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 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

The Graduated Benefit Option is NOT available to early and disabled retirees, or surviving spouses. The Graduated Benefit Option allows you to select either a one percent or two percent annual benefit increase. (No variations will be accepted). If this option is elected, your monthly benefit will be actuarially reduced. You will still be permitted to choose one of the optional forms of payment for your ongoing monthly benefit with exception of the Partial Lump Sum option, and Deferred Normal Retirement option.

This option is a once in a life time election and made at the time of your initial retirement. You may not make an election after receiving your initial benefit payment. If you return to work, your Graduated Benefit Option will be applied to your subsequent retirement.

PART C APPLICATION FOR GRADUATED BENEFIT OPTION

1. ☐ Check this box if you wish to elect the graduated benefit with an annual one (1) percent benefit increase.
2. ☐ Check this box if you wish to elect the graduated benefit with an annual two (2) percent benefit increase.

PART D AUTHORIZATION

I have reviewed and understand the above provisions. I understand that the Graduated Benefit Option is a once in a life-time election and my election is irrevocable.

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

INSTRUCTIONS

PART A PARTICIPANT IDENTIFICATION

For member identification, please provide all requested information.

PART B NOTICE OF MEMBER

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

PART C APPLICATION FOR GRADUATED BENEFIT OPTION

Complete this section to authorize NDPERS to actuarially reduce your monthly benefit payment to provide for an annual one or two percent benefit increase.

PART D AUTHORIZATION

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

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

☐ **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. 04-2024)

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)
Home Email Address	Home Phone Number

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

PART B PLAN

☐ **Apply to ALL DEFINED BENEFIT PLANS (default)**

Mark plan below only if designation should be applied to a specific plan:

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

PART C FINANCIAL INSTITUTION INFORMATION

I authorize the following amount to be deposited to the Financial Institution indicated.

Amount of Benefit to be Deposited: ☐ 100% (default) ☐ _____ % ☐ $ _____
☐ remaining % ☐ $ remaining amount
(Two forms must be submitted for % or $ of account.)

Attach a Voided Check or Complete section below. Deposit slips will not be accepted.

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 _____

PART D 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.

PART B PLAN

Indicate the plan you are requesting to update your banking information. If you have multiple plans under NDPERS, you can mark “All Plans”, if applicable. Otherwise, you must submit an application for each plan individually. If you do not specifically mark a plan, NDPERS will update all of your accounts in which you are receiving benefit payments.

PART C FINANCIAL INSTITUTION SECTION

- Check if you want 100% or only a portion of your benefit to be direct deposited
- Attach a Voided check or complete your financial institution information for your funds to be deposited.
    - Enter the name and routing number
    - Check the type of retirement account (checking or savings) and associated account number (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 to your correspondent bank account through 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 D 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. 03-2024)

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)
Home Email Address	Home Phone Number

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

PART B INSTRUCTIONS & EFFECTIVE DATE

☐ **Apply to ALL DEFINED BENEFIT PLANS (default) One W-4P will be submitted.**

Mark plan below if designation should be applied only to an individual plan (W-4P must also be submitted for each plan):

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

Effective Date

If no date or an ineligible date is entered, NDPERS will use an effective date based upon your earliest eligibility.

PART C FEDERAL WITHHOLDING ALLOWANCE

You must complete Form W-4P and submit to NDPERS. Tax Withholding is calculated for each account separately. Personal tax questions should be directed to your tax advisor, accountant, or the Internal Revenue Service Center.

- No Federal income tax withheld. You must write "*No Withholding*" in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5 on the W-4P.

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

Please Note: If you receive 8 months or more of monthly back payments, federal income tax in the amount of 20% and ND state income tax in the amount of 3.92% will be automatically withheld. You may elect no ND tax by marking here:

☐ No – DO NOT Withhold ND State Income Tax for the back payments only

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.

☐ No North Dakota monthly income tax withheld.
☐ Amount per month $ _____ I elect to have ND income tax withheld from my payment.
(percentage cannot be listed)

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.

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.

Clear Form

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. 03-2024)

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 APPLICANT INFORMATION

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

PART B EFFECTIVE DATE OF CHANGE

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

PART C QUALIFYING COBRA EVENT/REASON FOR CHANGE

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

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

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

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

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

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

***In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Section 3402. The individual's social security number will be used for tax reporting and as an identification number.

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

Continue to Page 2 for Payment Method and Authorization

PART D PAYMENT METHOD

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

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

☐ Withhold from bank account. Complete bank information below.

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

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

Telephone Number

Type of Account & Account Number

☐ Checking Account Number

☐ Savings Account Number

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

CANCELLATION POLICY

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

PART E APPLICANT AUTHORIZATION

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

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

Please review Page 3 for Additional Information and Instructions

.

PART A APPLICANT INFORMATION

For applicant identification, please provide all requested information.

PART B EFFECTIVE DATE OF CHANGE

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

PART C QUALIFYING COBRA EVENT/REASON FOR CHANGE

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

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

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

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

PART D PAYMENT METHOD

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

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

PART E APPLICANT AUTHORIZATION

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

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

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

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

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS

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53799

RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53799 (Rev. 03-2024)

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)
Home/Personal Email Address	Home/Cell Phone Number

PART B NDPERS GROUP HEALTH INSURANCE

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.

Select the level of health insurance coverage to be continued: ☐ Self Only ☐ Family* ☐ Decline/Cancel

***If electing family coverage, list all eligible covered dependents below. 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 Member	Gender	Date of Birth	Social Security Number*

Continue to Page 2 for Payment Method and Member Authorization.

PART C PAYMENT METHOD

Your first COBRA payment is due no later than 45 days after NDPERS receives your election and must be for all months owed to date. Subsequent payments are due by the 1st of each month.

NDPERS does not direct bill for premiums. **Failure to remit your premium by the due date of the 1st of the month will result in cancellation of COBRA continuation coverage.**

☐ Deduct from Pension Check* (only available for retirees of the following plans). Please indicate which retirement plan:

☐ NDPERS ☐ TFFR

☐ Withhold from bank account. Complete the information below and on page 2. Please write clearly and verify information for accuracy. Form will be returned if information provided is illegible.

Financial Institution Name	Financial Institution Routing Number (must be 9 digits)
☐ Checking Account Number	☐ Savings Account Number

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

CANCELLATION POLICY

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

PART D MEMBER AUTHORIZATION

I have read this application in its entirety, including the instructions, 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 Member (Electronic Signature will not be accepted)	Date

Please review Page 3 for Additional Information and Instructions

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. If declining or cancelling, mark "Decline/Cancel".

PART C PAYMENT METHOD

If continuing coverage, indicate your preferred method of payment. If selecting deduct from pension check, please indicate which retirement plan you would like to withhold the premium from. If selecting withhold from bank account, please provide the bank information and/or voided check you would like to withhold the premium from.

PART D MEMBER AUTHORIZATION

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

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS

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59562

Clear Form

RETIREE HEALTH INSURANCE WITH MEDICARE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 59562 (Rev. 03-2024)

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

PART A 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
Home/Personal Email Address		Home/Cell Telephone Number	

ELIGIBLE RETIREMENT GROUP (select one)

☐ NDPERS/NDHPRS/Job Service ☐ TFFR ☐ TIAA ☐ Ex-Legislator
☐ NDPERS Defined Contribution ☐ Alternate Retirement System

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
☐ Change Payment Method (complete Part G)
☐ Medicare Eligible
☐ Surviving Spouse
☐ Marriage (Date of Marriage _____/_____/_____)
☐ Loss of Other Coverage (Attach a Certificate of Creditable Coverage and complete Part F)
☐ Transfer from existing NDPERS policy. Current policyholder name & PERSLink ID: _____
☐ Remove Dependent/Spouse
☐ 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.

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. If you are adding a grandchild, submit Grandchild Eligibility Verification SFN 60983 and 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:
					☐ YES ☐ NO	☐ YES ☐ NO	A: B:

Continue to page 2

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

If you are newly enrolling or updating your health insurance due to loss of coverage, this section must be completed. Attach a Certificate(s) of Coverage or other documentation from your insurance company showing the coverage end dates and individuals insured. **Failure to provide documentation may affect eligibility to enroll/update your insurance.**

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**

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 for any dependents in Part D, in order to be eligible for coverage, you MUST submit a photocopy of each dependent's Medicare ID card showing Parts A & B. Each individual must complete the NDPERS Medicare Prescription Drug Plan (PDP) Applicant Enrollment Form.**

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

Continue to page 3 for payment method and member authorization

PART G PAYMENT METHOD

If you are drawing a pension from a NDPERS defined benefit plan (NDPERS or Job Service Retirement Plan) or the Teacher's Fund for Retirement (TFFR), your health insurance premium may be deducted from your pension check. If your pension check is not large enough, your health insurance premiums must be withheld from a bank account by completing the bank information section below.

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. Please complete the bank information section below.

NDPERS does not direct bill for premiums. **Failure to remit your premium by the due date of the 1st of the month will result in loss of COBRA continuation coverage.**

☐ Deduct from Pension Check* (only available for retirees of the following plans). Please indicate which retirement plan:
☐ NDPERS ☐ TFFR

☐ Withhold from bank account. Complete the information below and on page 2. Please write clearly and verify information for accuracy. Form will be returned if information provided is illegible.

Financial Institution Name	Financial Institution Routing Number (must be 9 digits)
☐ Checking Account Number	☐ Savings Account Number

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

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written request with member signature must be submitted along with one Prescription Drug Plan (PDP) Disenrollment-SFN 58861 for each family member insured under the Part D plan through NDPERS. The request must provide the contract holder's name, last four digits of social security number or NDPERS Member ID, and effective date. NDPERS must receive a cancellation request by the end of the month prior to the effective date. Cancellations will only be done at the end of the month. NDPERS cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

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

PART G PAYMENT METHOD

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 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

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.

MEDICARE HEALTH INSURANCE

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

53504

RETIREE DENTAL/VISION INSURANCE ENROLLMENT, CHANGE, OR CANCEL

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53504 (Rev. 03-2024)

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

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
Home/Cell Phone Number		Home/Personal Email Address	

ELIGIBLE RETIREMENT GROUP (select one)

☐ NDPERS/NDHPRS/Job Service ☐ TFFR ☐ TIAA ☐ Ex-Legislator
☐ NDPERS Defined Contribution ☐ Alternate Retirement System

PART B LEVEL OF COVERAGE

Both Insurance options below must be completed:

Dental Insurance: ☐ Retiree Only ☐ Retiree+Spouse ☐ Retiree+Child(ren) ☐ Retiree+Family ☐ Decline/Cancel
Vision Insurance: ☐ Retiree Only ☐ Retiree+Spouse ☐ Retiree+Child(ren) ☐ Retiree+Family ☐ Decline/Cancel

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 (Complete Part E. Must include 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. If Yes, please answer the following questions.
Is adult child disabled? ☐ No ☐ Yes If Yes, 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. 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.

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

PART E OTHER DENTAL OR VISION COVERAGE INFORMATION

If you are newly enrolled or updating your dental or vision insurance due to loss of coverage, this section must be completed. Attach a Certificate(s) of Coverage or other documentation from your insurance company showing the coverage end dates and individuals insured. **Failure to provide documentation may affect eligibility to enroll/update your insurance.**

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**

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 or Job Service Retirement Plan) or the Teacher's Fund for Retirement (TFFR), 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 by completing the bank information section below.

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. Please complete the bank information section below.

NDPERS does not direct bill for premiums. **Failure to remit your premium by the due date of the 1st of the month may result in cancellation of coverage.**

☐ Deduct from Pension Check* (only available for retirees of the following plans).
Please indicate which retirement plan: ☐ NDPERS ☐ TFFR

☐ Withhold from bank account. Complete the information below. Please write clearly and verify information for accuracy. Form will be returned if information provided is illegible.

Financial Institution Name	Financial Institution Routing Number (must be 9 digits)
☐ Checking Account Number	☐ Savings Account Number

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

Continue to Page 3

CANCELLATION POLICY

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

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

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50134

AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 50134 (Rev. 03-2024)

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

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

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

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

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

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

PART C FINANCIAL INSTITUTION INFORMATION

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

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

Type of Account & Account Number

☐ Checking Account Number

☐ Savings Account Number

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

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

INSTRUCTIONS AND CONDITIONS

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

PART A PARTICIPANT IDENTIFICATION

For member identification, please provide all requested information.

PART B MEMBER AUTHORIZATION

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

PART C FINANCIAL INSTITUTION INFORMATION

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

CANCELLATION INSTRUCTIONS

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

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

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

CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53512 (Rev. 09-2021)

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

PART A PARTICIPANT/QUALIFIED BENEFICIARY INFORMATION

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

PART B CONTINUATION OF COVERAGE ELECTION / WAIVER

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

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

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

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

PART C AUTHORIZATION OF APPLICANT

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

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

Entitlement to COBRA Coverage

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

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

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

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

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

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

Length of COBRA Coverage

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

COBRA Coverage Premiums

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

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

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

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

457 DEFERRED COMPENSATION PLAN ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 3803 (Rev. 12-2023)

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

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.

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