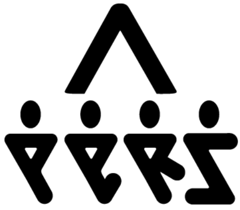

FLEXCOMP ENROLLMENT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53851 (Rev. 08-2023)

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

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

PART A EMPLOYEE INFORMATION

☐ New Election **Date of Hire** ________________

To participate in the Plan for the period ______________________ through December 31, 20____.

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

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

Group Life Employee Supplemental Insurance Premium up to $50,000 of coverage will automatically be pre-taxed. I decline this action.

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

PART C PREMIUM CONVERSION- PRE-TAX INSURANCE PREMIUMS

I elect to pretax the following insurance premiums, excluding the NDPERS administered group life insurance:

Company/Product Name

☐AFLAC-Accident
☐AFLAC-Cancer
☐AFLAC-Hospital Confinement
☐AFLAC-Hospital Intensive Care
☐AFLAC-Lump Sum Critical Illness
☐AFLAC-Specified Health Event Plan

☐Central United – Cancer
☐Colonial Life - Accident
☐Colonial Life - Cancer
☐Colonial Life - Medical Bridge

☐Delta Dental - NDPERS
☐Total Dental Admin-Elite Choice (TDA)
☐Superior Vision - NDPERS
☐USAble – Accident Elite
☐USAble – Cancer Care Elite
☐USAble – Hospital Confinement

☐Custer Health Unit Only –Dental ☐Custer Health Unit Only - Vision

PART D MEDICAL SPENDING REIMBURSEMENT ACCOUNT

Medical Spending Annual Maximum $3,050	What is the total ANNUAL amount you want payroll deducted for the Plan Year? $ ANNUAL AMOUNT

PART E DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

PART F AUTHORIZATION

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

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

ENROLLMENT

New employees who meet eligibility requirements must enroll within 31 days of their hire date. Your participation will begin the first day of the month the contribution is received.

ENROLLMENT FORM INSTRUCTIONS

PART A EMPLOYEE INFORMATION

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

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

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

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

PART C PREMIUM CONVERSION-PRETAX INSURANCE PREMIUMS

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

PART D MEDICAL SPENDING REIMBURSEMENT ACCOUNT

Enter amount you want payroll deducted per pay period. Enter the number of payroll checks you will receive beginning with the first month a payroll deduction will be withheld through the end of the plan year on December 31. Multiply the amount to be deducted per pay period by the number of payroll periods in the year and enter this amount in Total Salary Redirection for the Plan Year. Your election cannot exceed the plan year maximum $3,050.

PART E DEPENDENT CARE REIMBURSEMENT ACCOUNT

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

PART F AUTHORIZATION

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

RETURN FORM TO YOUR AGENCY'S PAYROLL/HUMAN RESOURCE DEPARTMENT. RETAIN A PHOTOCOPY FOR YOUR RECORDS.