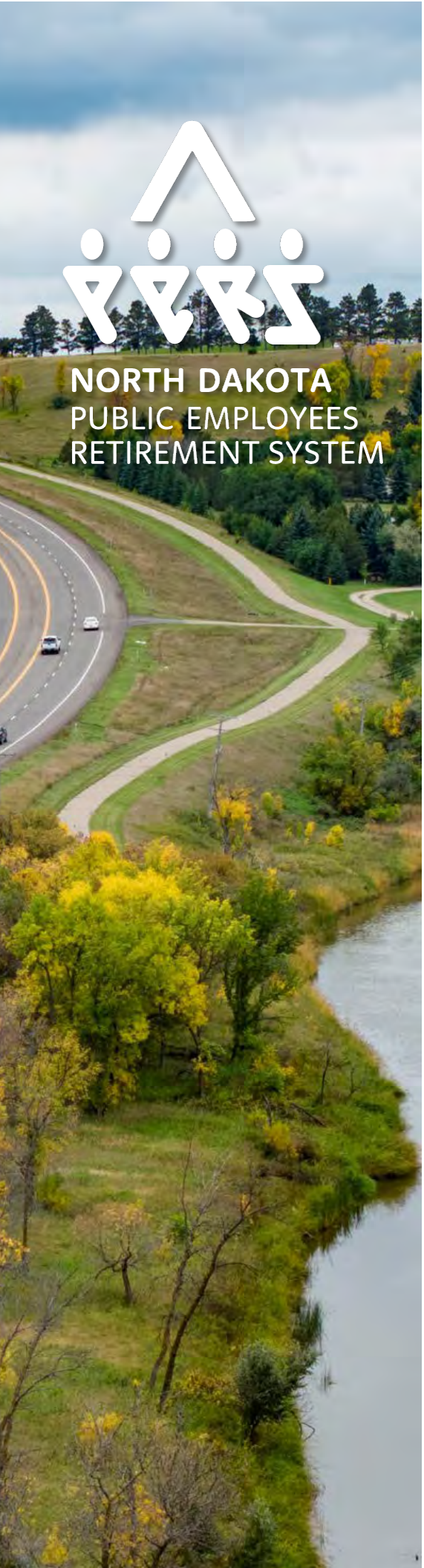

Defined Contribution Retirement Forms Packet

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

Retirement Forms – Required for Benefit Payment

- Application for Periodic Payments for Defined Contribution [**SFN-59045**]
- Legible Photocopies of Birth Certificate, Spouse's Birth Certificate and Marriage Certificate
- Designation of Beneficiary for the Group Retirement [**SFN-2560**]

Insurance Forms – Required

Health - Continuation of Coverage

- Continuation of Group Insurance Coverage (COBRA) [**SFN-14120**]
  (Complete only for family members electing individual coverage if currently covered on NDPERS Dakota Plan or HDHP plan)
- Retiree Continuation of Group Health Insurance Coverage (COBRA) [**SFN-53799**]
  (Complete if currently covered on NDPERS Dakota Plan or HDHP Plan)

Health - Medicare Coverage

- Retiree Health Insurance Application with Medicare [**SFN-59562**]
  (If either you or a dependent is over age 65)
- Medicare Prescription Drug Plan (PDP) Individual Enrollment Form [**SFN-58860**]
  (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)

Life - Vision - Dental - Long Term Care - Flexible Medical Spending

- Retiree Life Insurance Application [**SFN-53622**]
  (If currently enrolled, complete to continue coverage)
- Retiree Vision\Dental Insurance Enrollment, Change, or Cancel [**SFN-53504**]
  (Complete if continuing, enrolling, or canceling coverage)
- Continuation of Coverage in Medical Spending Account (COBRA) [**SFN-53512**]
  (Complete if continuing coverage for the rest of the plan year)
- 457 Deferred Compensation Plan Enrollment/Change [**SFN-3803**]

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APPLICATION FOR DEFINED CONTRIBUTION PLAN PERIODIC PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 59045 (Rev. 01-2025)

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

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): _____
(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.

An Empower 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. Note: You are required to receive at least one periodic payment each calendar year.

Section 2: Check your retiree health insurance credit option, if applicable. 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.

2560

DESIGNATION OF BENEFICIARY FOR THE GROUP RETIREMENT PLAN

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 2560 (Rev. 08-2024)

Clear Form

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

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

PART A MEMBER INFORMATION

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

PART B PLAN

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

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

☐ **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 BENEFICIARY DESIGNATION

The percentage distribution upon your death for all primary beneficiaries **must equal 100%**; likewise, for contingent beneficiaries. If shares do not equal 100%, I grant NDPERS the authority to amend each of my beneficiaries (up to +/- 1%) to pay 100% of my total account balance with up to a 1% difference being credited to the eldest. If beneficiaries are listed but no shares designated, I grant NDPERS the authority to divide shares equally between all beneficiaries with up to a 1% difference being credited to the eldest.

PRIMARY BENEFICIARY(IES) – Must equal 100%

Name	Relationship	DOB	SSN#	%	Address and Phone Number

SECONDARY BENEFICIARY(IES) – Must equal 100%

Name	Relationship	DOB	SSN#	%	Address and Phone Number

PART D SPOUSE AUTHORIZATION (if applicable)

Only if you name a primary beneficiary other than or in addition to your spouse, your spouse must sign below.
If a vested member 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 Waiver of Benefits (Electronic Signature will not be accepted)	Date

PART E MEMBER AUTHORIZATION

I understand that this election revokes any previous retirement account beneficiary designations. I understand that, if married, upon divorce this designation is valid until signed divorce decree is received and a new beneficiary designation is submitted. I have read and understand the terms and conditions 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:** The percentage of distribution upon your death for all primary beneficiaries must equal 100%; likewise, for contingent beneficiaries.

   Primary. Your primary beneficiary is the individual or individuals, trust, charity, or other party you designate to receive your assets after your death. If a primary beneficiary(ies) is deceased at the time of your death, his or her portion of your assets will be divided proportionately among your surviving primary beneficiary(ies), if any.

   Secondary. Your secondary beneficiary or beneficiaries will inherit your assets only if you have no surviving primary beneficiaries at the time of your death.
   - **If shares do not equal 100%,** I grant NDPERS the authority to amend each of my beneficiary designations (up to +/- 1%) to pay 100% of my total account balance with up to a 1% difference being credited to the eldest.
   - **If beneficiaries are listed but no shares designated**, I grant NDPERS the authority to divide shares equally between all beneficiaries with up to a 1% difference being credited to the eldest.
   - **If no valid beneficiary form is on file**, NDPERS will issue payment to the member’s estate.

   Since this distribution may not reflect the member’s preference, we recommend the member be sure to designate the percent share for each listed beneficiary and to ensure 100% of the total account balance is accounted for with the share designation.

6. 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.

CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 14120 (Rev. 08-2024)

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

PART A 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			

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. Members have 45 days from when NDPERS receives the election to remit COBRA payment to NDPERS.

NDPERS requires that the same bank account be used for all insurance premiums with that same payment method.

☐ 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

.

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 for all months due. **Failure to remit your premium by the due date of the 1st of the month will result in loss of insurance coverage.**

NDPERS requires that the same bank account be used for all insurance premiums with that same payment method.

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. 06-2024)

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

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.

NDPERS requires that the same bank account be used for all insurance premiums with that same payment method.

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. NDPERS requires that the same bank account be used for all premiums with that same payment method.

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

RETIREE HEALTH INSURANCE WITH MEDICARE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 59562 (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

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 58856 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:

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.

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.

NDPERS requires that the same bank account be used for all insurance premiums with that same payment method. Payment method elected for health insurance will apply to applicable Part D enrollment(s).

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

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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.

RETIREE LIFE INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53622 (Rev. 08-2024)

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

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

ELIGIBLE RETIREMENT GROUP (select one)

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

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

Spouse supplemental life insurance cannot be more than 50% of the total member life insurance.

* 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

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.

NDPERS requires that the same bank account be used for all insurance premiums with that same payment method.

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 2

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.

Enter percent share for each beneficiary. The total **must equal 100%**. If the total share does not equal 100%, I grant NDPERS the authority to amend each of my beneficiary designations (up to +/-1%) with up to a 1% difference being credited to the eldest for any uneven split. **If beneficiaries are listed but no shares designated, I grant NDPERS the authority to divide shares equally between all beneficiaries with up to a 1% difference being credited to the eldest if there is any uneven split.**

PRIMARY BENEFICIARY(IES) – Total must equal 100%

Name	Relationship	Social Security #	Birthdate	% Share	Address and Phone Number

SECONDARY BENEFICIARY(IES) – Total must equal 100%

Name	Relationship	Social Security #	Birthdate	% Share	Address and Phone Number

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 review Page 3 for Additional Information and Instructions

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Part A Member Information

For member identification, please provide all requested information. Indicate which group you are a member of in order to enroll in the retiree life insurance.

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 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. NDPERS requires that the same bank account be used for all premiums with that same payment method.

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 all primary beneficiary(ies) predecease member.

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

The benefit will be distributed as directed by the designation. Enter percent share for each beneficiary. All beneficiary designations shall equal 100% of the benefit. If the total share does not equal 100%, NDPERS shall amend each beneficiary’s allocation (up to 1% increase or decrease) to reach the 100% total. **If beneficiaries are listed but no shares designated, NDPERS will divide shares equally between all beneficiaries with up to a 1% difference being credited to the eldest if there is any uneven split.**

If a named beneficiary does not survive, the share will be distributed among any surviving beneficiaries in proportion to the shares designated. 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 and that the total equals 100%.

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

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53504

RETIREE DENTAL/VISION INSURANCE ENROLLMENT, CHANGE, OR CANCEL

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53504 (Rev. 06-2024)

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/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 58856 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.

NDPERS requires that the same bank account be used for all insurance premiums with that same payment method.

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

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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CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53512 (Rev. 09-2021)

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

PART A PARTICIPANT/QUALIFIED BENEFICIARY INFORMATION

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

PART B CONTINUATION OF COVERAGE ELECTION / WAIVER

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

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

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

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

PART C AUTHORIZATION OF APPLICANT

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

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

Entitlement to COBRA Coverage

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

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

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

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

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

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

Length of COBRA Coverage

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

COBRA Coverage Premiums

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

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

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

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

3803

457 DEFERRED COMPENSATION PLAN ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 3803 (Rev. 12-2024)

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

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

PART B PROVIDER INFORMATION

Choose one: ☐ Empower Companion Plan ☐ Bravera ☐ Nationwide ☐ Bank of North Dakota

☐ Grandfathered State of ND 457 plan. Enter Provider Name:_____
* not available to newly enrolling members

SFN 3803 must be completed for each provider if participating with more than one provider.

Agent Name (no agent can be named for the Companion plan)	Agent Telephone Number and/or email

PART C

COMPLETE IF NEWLY ENROLLED AFTER DECEMBER 31, 2024 IN THE DEFINED CONTRIBUTION PLAN

☐ I am enrolled in the Defined Contribution Plan 2025 Tier 3. If applicable, I elect my employer match to be sent to the provider selected above.

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

PART D CHECK ALL THAT APPLY

☐ 1. New Application
☐ 2. Increase Deduction
☐ 3. Decrease Deduction
☐ 4. Suspend Deduction (Includes full-time to part-time)
☐ 5. Lump sum Sick & Annual Leave ☐ Exclude Regular Monthly Deduction
Required for lump sum sick and annual leave-Last Date of Employment
_____/_____/_____ (date required)
* contact your employer in order for your lump sum deduction to be entered correctly.

☐ 6. Age 50 or older: Annual Catch-up
☐ 7. Regular 3 Year Catch-up
☐ 8. Provider Change
☐ 9. Change in Agent only
☐ 10. USERRA Missed Contributions

PART E CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION

Must be completed if you checked 1, 2, 3,5, 6,7, or 10 in Part D

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 F SALARY REDUCTION AUTHORIZATION

Must be completed if you checked 1, 2, 3,5, 6,7, or 10 in Part D

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 G 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 insure the authorized amount is withheld from my paycheck.

PART G 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 D #5 or the date listed in Part F.)

Participant's Signature (Electronic Signature will <u>not</u> be accepted)	Date (Must be prior to the date on Part F)

ANNUAL LIMITS

Annual Limit for 2025:	$23,500
Age 50+ Limit for 2025:	$31,000
Regular 3 Year Catchup:	$47,000 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

Eligible 457 Providers include Empower Companion Plan, Bravera, Nationwide and Bank of North Dakota.
If you have an account with a grandfathered State of ND 457 plan, please list the plan. Grandfathered plans are not available to newly enrolling members**.**

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
ELIGIBILE FOR DEFINED CONTRIBUTION PLAN 2025 (TIER 3 DC 2025)

NDCC 54-52.6-01 defines an eligible employee who is first enrolled effective January 1, 2025, in the Defined Contribution Plan as having the same meaning as provided under section 54-52-02.15. According to 54-52.6-09, all eligible employees of a participating employer must be immediately enrolled in the NDPERS Defined Contribution Plan within the first month of employment.

Per NDCC 54-52-02.15, "eligible employee" means a permanent employee who meets the following:

1) is at least eighteen years of age;
2) becomes a participating member after December 31, 2024 and
3) is not eligible to participate in the law enforcement plan, judges' plan, highway patrol plan, teachers' fund for retirement plan, or alternative retirement plan established under section 15-10-17 for university system employees.

After December 31, 2024, under 54-52.6-02.1, eligible employees includes the following:

1) Temporary or Part-time employees within 180 days of beginning employment must complete the Agreement/Waiver of Participation for Optional Defined Contribution Retirement Plan SFN 54366.
2) Elected or appointed state officials enrolled for the first time, from and after the date that individual qualifies and takes office.
3) Nonstate appointed officials of participating employers within the first month of taking office.

Elected officials specifically of participating counties, at their individual option, may enroll within the first six months of their term.

The employee must sign and date this section.

Defined Contribution 2025 (Tier 3 DC 2025): participation in a NDPERS State of ND 457 Plan also allows up to a 3% match from my employer if election in the Defined Contribution Plan was not maximized within the first 30 days of employment.

Part D CHECK ALL THAT APPLY
Check the applicable box(s).

Box 5 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.
Box 7 Regular 3 Year Catch-up –457 Deferred Compensation Catch-up Worksheet SFN 51501 MUST accompany this form.
Box 8 Provider Change - YOU MUST complete 2 Participant Agreement forms: *One for the new provider & √ 'New Application' 2. One to stop contributions to old provider & √ 'Suspend Deduction.'
Box 9 Change in Agent only - Complete Part A, B & F of this form

Note: All Defined Benefit Retirement Plans - enrollment automatically maximizes retirement savings by vesting in the employer's contribution through Portability Enhancement Provision (PEP).

Defined Contribution (Tier 1 DC) or Defined Contribution 2020 (Tier 2 DC2020) - there is no matching, PEP or employer match.

Defined Contribution 2025 (Tier 1 DC2025) – there is a matching employer contribution, up to 3% (if not matched at 3% in the DC plan).

PART E 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 F 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 G 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.

Defined Benefit Plan and Defined Contribution Plan: The employee's signature in this section **will authorize** a reduction in the employee's monthly wage and contribution to a deferred compensation plan.