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:

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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