WAIVER OF INSURANCE COVERAGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58819 (Rev. 01-2014)

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PART A EMPLOYEE IDENTIFICATION	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID

PART B WAIVER OF INSURANCE COVERAGE

Check the applicable insurance plan:

☐Health Insurance ☐Dental Insurance ☐Vision Insurance ☐Life Insurance

I have been informed that I am eligible to apply for insurance coverage under my employer's Benefit Plan issued I do not wish coverage for:

☐Myself ☐Spouse ☐Eligible Dependents ☐Myself and Entire Family

Reason coverage is being waived:

☐I have coverage through my spouse's employer
☐I have other individual coverage
☐I have Medicare coverage
☐Other:_____

PARTC EMPLOYEE AUTHORIZATION

I hereby forfeit insurance coverage at this time. I fully understand that if I or my Eligible Dependents desire to be covered under my employer's insurance Benefit Plan in the future, I and my Eligible Dependents may have a Waiting Period for Preexisting Conditions and one of the following must apply:

1. If at the time I am declining coverage, it is because:
   a. I or my Eligible Dependents have other group insurance coverage, and that coverage is either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours) or employer contributions toward such coverage was terminated; or
   b. Coverage was under COBRA at the time I declined coverage and that coverage has been exhausted.

   Under (a.) and (b.) above, I must complete a membership application within 31 days after I lose my current coverage.

2. If I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may enroll myself and my Eligible Dependents, provided that I request enrollment within 31 days of marriage, birth, adoption or placement for adoption.

3. If I do not meet requirements under 1 or 2 above, I may apply as a Late Enrollee, Late Enrollees must request enrollment during the Enrollment Period.

_____ _____

Employee's Signature Date