60711

ACKNOWLEDGEMENT OF OR DECLINE OFFER OF HEALTH INSURANCE COVERAGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 60711 (Rev. 12-2014)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
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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 ACKNOWLEGEMENT OF OFFER OF HEALTH INSURANCE COVERAGE

(FOR STATE EMPLOYEES COVERED UNDER NDPERS THROUGH SPOUSE OR PARENT)

☐ I understand that I am offered adequate and affordable coverage as a "full-time" employee as defined by the Affordable Care Act. I am already covered under the NDPERS health insurance through my spouse or parent. I understand that my coverage will remain through my spouse or parent unless my spouse or parent terminates employment or ceases to be an Eligible Employee, at which time I will have the opportunity to apply for coverage within 31 days of the event as an Eligible Employee.

_____ _____
Employee's Signature Date

PART C DECLINE OFFER OF HEALTH INSURANCE COVERAGE

I understand that I am offered adequate and affordable coverage as a "full-time" employee as defined by the Affordable Care Act. I understand that the coverage is offered to me and my Eligible Dependents. I decline for one of the following (check applicable) reasons:

Please check the applicable box:

☐ I have coverage through my spouse's or parent's employer (non-NDPERS)
☐ I have Medicare coverage
☐ I have other individual coverage (non-NDPERS)
☐ Other:_____

I understand that in declining this offer of health insurance coverage, I may not be eligible to apply for a federal tax subsidy through the Marketplace Exchanges. 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