60036

HEALTH INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 60036 (Rev. 01-2014)

NDPERS ● PO Box 1657 ● Bismarck ● North Dakota 58502-1657
(701) 328- 3900 ● 1-800-803-7377 ● Fax 701-328-3920

PART A MEMBER IDENTIFICATION

Employee Name (Last, First, Middle)		NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth	Daytime Telephone Number
Organization Name		NDPERS Organization ID

Active in the Military? ☐No ☐Yes

PART B INSURANCE ELECTION

Effective Date of Change (MM-DD-YYYY):

Section 1 Change Reason:

☐New Coverage (I do not have existing coverage)
☐Annual Enrollment
☐Cancel Coverage
☐Remove Dependent
☐Loss of Other Coverage
☐Transfer Employment:
from_____ to _____
☐Transfer from existing policy **(Complete Part E)**

☐Add Dependent: Is this an adult child? ☐No ☐Yes. Please answer the following questions.
Is adult child married? ☐No ☐Yes
Is adult child Disabled? ☐No ☐Yes

Section 2 Type of Coverage:

☐**PPO/Basic Health Plan**

PPO/Basic Health Plan Authorization: By signing this application I represent that I am joining the PPO/Basic Health Plan. I acknowledge I have had the opportunity to review the terms and conditions relating to participation in the PPO/Basic Health Plan.

_____
Member's Signature

_____
Date of Signature

☐**High Deductile Health Plan/Health Savings Account (HDHP/HSA)** This option is available only to employees of state agencies, the university system, and district health units.

HDHP/HSA Authorization: By signing this application I represent that: (1) I am joining a HDHP/HSA; (2) I will not be covered by any other health plan that is not a HDHP (including my spouse's general-purpose health care Flexible Spending Account, which is a non-HDHP) for the upcoming plan year or enrolled in Medicare; I have not enrolled in my employers general-purpose health care Flexible Spending Account for the upcoming plan year and (3) I cannot be claimed as a dependent on another person's tax return. I understand that a HSA will be established on my behalf. I acknowledge I have had an opportunity to review the terms and conditions relating to participation in the HDHP/HSA.

_____
Member's Signature

_____
Date of Signature

Section 3 Level Of Coverage for Plan:

☐Single Coverage (Self Only)
☐Family Coverage (Self and Spouse OR Self and Eligible Child(ren) OR Self, Spouse, Eligible Child(ren)

PART C DEPENDENT INFORMATION

1. List all family members to be covered under the plan **indicated in Part B, Section 1**, other than yourself.
   a. Indicate dependent's address below name if address is different from yours.
   b. For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
   c. For Marital Status, enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed
2. If your marital status is single and you are applying for family coverage, you are required to attach a copy of the state birth certificate for each Eligible Dependent unless previously submitted.

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 then subscriber, indicate address under name	Relationship	Gender	Date of Birth	Social Security Number	Marital Status	Court Ordered Coverage	Active Military
	Spouse					N/A	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes

PART D MEDICARE COVERAGE INFORMATION

Are you or spouse or any of your Eligible Dependents currently covered by Medicare?
☐No, skip to next section ☐Yes, complete the following:

Are you or spouse or any of your Eligible Dependents currently covered by Medicare due to End Stage Renal Disease?
☐No, skip to next section ☐Yes, complete the following:

Individual on Medicare (Last, First, Middle)	Medicare Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date

PART E OTHER COVERAGE INFORMATION

Are you, your spouse or any of your Eligible Dependents currently or were previously covered by another insurance benefit plan(s), **INCLUDING NDPERS BENEFIT PLAN(S)**? ☐No, skip to next section ☐Yes, **please complete this section AND attach Certificate(s) of Coverage or other documentation from your insurance company. Failure to provide documentation may affect your waiting period.**

Other Coverage Name & Phone Number	Policy Number	Policyholder (last, first, middle)	Date of Birth	Policy Coverage Dates (mm-dd-yy)	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, 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

Person's Name	Injury Date (MM-DD-YY)	Type of Injury	Company Providing Benefits & Phone Number

PART F MEMBER AUTHORIZATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (front and back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively cancelling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

- I understand members are subject to limitations and exclusions outlined in the relevant Benefit Plan/Policy.
- I understand that in the event the group through which I am enrolled elects to terminate, the Insurance Carrier has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.
- I understand conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with the Insurance Carrier and has enrolled as a group with another Insurance Carrier.
- I understand, in the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit to NDPERS.
- I acknowledge that the Summary of Benefits and Coverage and other related plan information is available on the NDPERS website at www.nd.gov/ndpers.

Please retain a copy of this Application for your records

_____ _____

Member's Signature Date of Signature