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| **53621**  **EMPLOYER VERIFICATION OF INSURANCE COVERAGE**  NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  SFN 53621 (Rev. 06-2015)  **NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657**  **(701) 328-3900 • 1-800-803-7377 • Fax 701-328-3920**  **Instructions:** Please complete Part A and B information and forward the form to the former employer to verify coverage in Parts C, D, E, and to sign Part F. These Parts must be completed by an authorized staff employee of the employer. This information is used to determine eligibility for insurance provided through the North Dakota Public Employees Retirement System (NDPERS). This information must be returned to NDPERS accompanied by the applicable enrollment form(s).   |  |  |  |  | | --- | --- | --- | --- | | **PART A NDPERS MEMBER INFORMATION** | | | | | NDPERS Member Name (Last, First, Middle) | | NDPERS Member ID (If applicable) | | | **PART B EMPLOYEE AND EMPLOYER INFORMATION** | | | | | Employee Name (Last, First, Middle) | Employer Name | | | | Date Employment Terminated | | | | | **PART C HEALTH INFORMATION** | | | | | Month and Year the Employee is Covered on Employer Group Insurance Billing: **From:\_\_\_\_/\_\_\_\_/\_\_\_\_ Through:\_\_\_/\_\_\_\_/\_\_\_\_** | | | | | Does employee currently participate in the employer sponsored HEALTH plan?  No  Yes, Current level of coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Has employee been covered under COBRA?  No  Yes, If yes, Beginning date of COBRA: \_\_\_\_/ \_\_\_\_/ \_\_\_\_  Ending date of Health Coverage: \_\_\_\_/ \_\_\_\_/ \_\_\_\_ | | | | | **PART D DENTAL INFORMATION** | | | | | Last Month and Year the Employee is Covered on Employer Group Insurance Billing: \_\_\_\_/ \_\_\_\_\_\_\_ | | | | | Does employee currently participate in the employer sponsored DENTAL plan?  No  Yes, Current level of coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Has employee been covered under COBRA?  No  Yes, If yes, Beginning date of COBRA: \_\_\_\_/ \_\_\_\_/ \_\_\_\_  Ending date of Dental Coverage: \_\_\_\_/ \_\_\_\_/ \_\_\_\_ | | | | | **PART E VISION INSURANCE** | | | | | Last Month and Year the Employee is Covered on Employer Group Insurance Billing: \_\_\_\_/ \_\_\_\_\_\_\_ | | | | | Does employee currently participate in the employer sponsored VISION plan?  No  Yes, Current level of coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Has employee been covered under COBRA?  No  Yes, If yes, Beginning date of COBRA: \_\_\_\_/ \_\_\_\_/ \_\_\_\_  Ending date of Vision Coverage: \_\_\_\_/ \_\_\_\_/ \_\_\_\_ | | | | | **PART F EMPLOYER CERTIFICATION** | | | | | Signature of Authorized Personnel | | | Date of Signature | | Telephone Number: | | | | |