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| **53706-****{stdMbrPERSLinkID}**   |  |  | | --- | --- | | {SFNLogo} | **NOTICE OF TRANSFER**  NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  SFN 53706 (Rev. 11-2015)  {SFNAddress} |      |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **PART A MEMBER INFORMATION** | | | | | | | Name (Last, First, Middle) **{stdMbrFullNameLFM}** | | | | | NDPERS Member ID **{stdMbrPERSLinkID}** | | Last Four Digits of Social Security Number **{stdMbrLastFourDigitsOfSSN}** | | | | | Date of Birth **{stdMbrDateOfBirth}** | | **PART B CURRENT EMPLOYER** | | | | | | | Organization Name | | | | | NDPERS Organization ID | | Last Date of Service with Current Agency | | Date of Last Regular Paycheck | | | | | Last Month Insurance Premium(s) will be paid by your agency/or this employee  (Month & Year) : | | | | Projected Accumulated hours of sick leave to date of transfer: | | | **PART C CURRENT PLAN INFORMATION** (Check yes or no for all NDPERS plans the employee is currently participating in) | | | | | | | Defined Benefit Plan  Defined Contribution Plan  Deferred Comp (457)  Other 457/403(b)  Group Health Insurance  Group Life Insurance  Group Dental Insurance  Group Vision Insurance  Long Term Care Insurance  FlexComp Plan | No Yes  No Yes  No Yes, Provider(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Deduction: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (if more than one provider- attach a detailed memo)  No Yes, Single Family  No Yes, $3,500 Basic Life  Supplemental $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.00  Dependent $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.00  Spouse Supplemental $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.00  No Yes, Individual Only  Individual & Spouse  Individual & Child(ren)  Family  No Yes, Individual Only  Individual & Spouse  Individual & Child(ren)  Family  No Yes, Premiums: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse  No Yes, Medical Spending, $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Annual Deduction  Dependent Care, $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Annual Deduction | | | | | | **PART D AUTHORIZATION OF CURRENT AUTHORIZED AGENT** | | | | | | | I certify that the above information is true and correct.  Authorized Agent Signature Telephone Number Date of Signature | | | | | | | **PART E NEW EMPLOYER** | | | | | | | Organization Name | | | | | NDPERS Organization ID | | First Day of Service with New Agency: | | | Date of First Regular Paycheck | | | | New Job Classification: Classified State Non-Classified State Non-State State University System TIAA-CREF  Judge Law Enforcement Elected Official Appointed Official ND TFFR  Employment Type: Permanent Temporary  Status: Contributing Non-Contributing  Seasonal: 6 Months 9 Months 10 Months 11 Months | | | | | | | **PART F AUTHORIZATION OF NEW AUTHORIZED AGENT** | | | | | | | I certify that the above information is true and correct.  Authorized Agent Signature Telephone Number Date of Signature | | | | | | |

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| NOTICE OF TRANSFER  SFN 53706 (Rev. 11-2015) Page 2  **INSTRUCTIONS**  Often employees will terminate their position with an employer participating in NDPERS and take a job with another employer who is also participating in NDPERS. Therefore, the employee’s membership is transferred to the new employer and membership IS NOT terminated unless the new employer does not offer or is not eligible for a particular NDPERS plan.  **Part A Member Information**  For member identification, please provide all requested information.  **Part B Current Employer**  A NDPERS Transfer Kit must be given to the employee to complete. **A completed kit must accompany the Notice of Transfer SFN 53706.**  Indicate the current employer’s name and department number. Indicate the last day of employment and the last regular paycheck issued to the employee.  Indicate last month insurance premiums will be paid by your agency/employee.  Indicate the projected accumulated unused sick leave at the date of transfer.  **Part C Current Plan Information**  Check the appropriate box on the right side for all NDPERS plans. If the employee does not participate in a plan, check the NO box. If the employee does currently participate, check the YES box and complete all applicable boxes following, if any.  **Part D Authorization of Authorized Agent**  The current agency’s designated NDPERS authorized agent must sign and date this form.  **Part E New Employer**  This form should be forwarded to the new employer. The new employer should indicate the organization name and NDPERS ID; as well as, the first day of employment and the employee’s first regular paycheck.  The new employer should transfer any eligible plan participation as indicated in Part C with NO change in the levels of coverage.  Any plans the employee currently participates in but not offered or eligible through new employment will be terminated.  Any plans the employee currently does not participate in but now is offered or eligible through new employment, the employer must enroll as a new employee. See your NDPERS Employer’s Guide for instructions for enrolling a new employee.  **Part F Authorization of Authorized Agent**  The new agency’s designated NDPERS authorized agent must sign and date this form. |