{stdlongdate} Member ID: {stdMbrPERSLinkID}

{stdMbrFullName}

{stdMbrAdrCorStreet1}

{x stdMbrAdrCorStreet2}

{stdMbrAdrCorCity} {stdMbrAdrCorState} {stdMbrAdrCorZip}

**RE: NDPERS RETIREMENT ACCOUNT OF** **{deceasedName} (DECEASED)** **{deceasedPERSLinkID}**

Dear {stdMbrSalutation}:

We are sorry to hear of {DeceasedFirstName}’s death and wish to extend our sincere sympathy to you and your family members.

Because {DeceasedFirstName} is associated with the following accounts/plans, we will need you to provide updated information to keep our system current.

A certified copy of {DeceasedFirstName}’s Certificate of Death has to be provided to NDPERS. A certified copy can be obtained from the local registrar of vital records.

**Plan Form**

{x when DeceasedIsBeneficiaryForDBOrDCPlan has “Y”}

Retirement Designation of Beneficiary SFN 2560

{x endblock}

{x when MemberIsEnrolledInDefComp has “Y”}

Deferred Comp Please contact your providers

{x endblock}

{x when DeceasedIsBeneficiaryForLifePlanA**nd**FamilyRelationshipI**s**Spouse has “N”}

Life Insurance Life Insurance Designation of Beneficiary Change SFN 53855

{x endblock}

{x when DeceasedIsBeneficiaryForLifePlan**And**FamilyRelationshipI**s**Spouse has “Y”}

Life Insurance Life Insurance Enrollment/Change SFN 53803

{x endblock}

{x when DeceasedIsDependentInHealthPlan has “Y”}

Health Insurance Health/Dental/Vision Insurance Application or Change SFN 58792

{x endblock}

{x when DeceasedIsDependentInVisionPlan has “Y”}

Vision Insurance Health/Dental/Vision Insurance Application or Change SFN 58792

{x endblock}

{x when DeceasedIsDependentInDentalPlan has “Y”}

Dental Insurance Health/Dental/Vision Insurance Application or Change SFN 58792

{x endblock}

Please complete the requested forms and return to your human resource/payroll department to review, update your payroll records, and disburse to NDPERS.

{x when MemberIsEnrolledInDependentSupplementalLifeInsurance has “Y”}

**DEPENDENT LIFE INSURANCE CLAIM:**

{x when FamilyRelationshipIsSpouseAndMemberIsEnrolledInSpouseSupplLife has “N”}

Your { DeceasedFirstName } was covered under your dependent supplemental coverage in the amount of {DependentSupplementalLifeAmount}

{x endblock}.

{x when FamilyRelationshipIsSpouseAndMemberIsEnrolledInSpouseSupplLife has “Y”}

Your { DeceasedFirstName } was covered under your dependent supplemental coverage in the amount of {DependentSupplementalLifeAmount} and spouse supplemental in the amount of {SpouseSupplementalLifeAmount}

{x endblock}.

Enclosed you will find a *Life Insurance Claim* form where you must complete the "B*eneficiary Statement”* section in its entirety. Return the completed claim form to NDPERS and our office will forward the information to the life insurance company for processing. In approximately ten business days from the date o f filing, you will receive a payment directly from the life insurance company.

{x endblock}

**LONG TERM CARE INSURANCE:**

{x when LTCAccountExistForDeceased has “N”}

Our records indicate that {DeceasedFirstName} did not participate in the NDPERS Long Term Care plan.

{x endblock}

{x when LTCAccountExistForDeceased has “Y”}

Our records indicate that {DeceasedFirstName} participated in the NDPERS Long Term Care plan. The policy will be cancelled effective the end of the month the death occurred.

{x endblock}

If you have any questions, please call NDPERS at {stdNDPERSPhoneNumber} or {stdNDPERSTollFreePhoneNumber}.

Sincerely,

NDPERS Benefits Division

Enclosure(s) –

{x when DeceasedIsBeneficiaryForDBOrDCPlan has “Y”}

Designation of Beneficiary SFN 2560

{x endblock}

{x when DeceasedIsBeneficiaryForLifePlanA**nd**FamilyRelationshipI**s**Spouse has “N”}

Life Insurance Designation of Beneficiary Change SFN 53855

{x endblock}

{x when DeceasedIsBeneficiaryForLifePlan**And**FamilyRelationshipI**s**Spouse has “Y”}

Life Insurance Enrollment/Change SFN 53803

{x endblock}

{x when DeceasedIsDependentInHealthPlan has “Y”}

Health/Dental/Vision Insurance Application or Change SFN 58792

{x endblock}

{x when DeceasedIsDependentInVisionPlan has “Y”}

Health/Dental/Vision Insurance Application or Change SFN 58792

{x endblock}

{x when DeceasedIsDependentInDentalPlan has “Y”}

Health/Dental/Vision Insurance Application or Change SFN 58792

{x endblock}

{x when MemberIsEnrolledInDependentSupplementalLifeInsurance has “Y”}

Life Insurance Claim Form

{x endblock}