{stdlongdate} Member ID: {stdMbrPERSLinkID}

{stdMbrFullName}

{stdMbrAdrCorStreet1}

{x stdMbrAdrCorStreet2}

{stdMbrAdrCorCity} {stdMbrAdrCorState} {stdMbrAdrCorZip}

**{x when Dental has “Y”}**

**RE: DENTAL INSURANCE COVERAGE**

**{x endblock}**

**{x when Health has “Y”}**

**RE: HEALTH INSURANCE COVERAGE**

**{x endblock}**

**{x when Vision has “Y”}**

**RE: VISION INSURANCE COVERAGE**

**{x endblock}**

Dear {stdMbrSalutation}:

{x when Dental has “Y”}

Enclosed is a Retiree Vision/Dental Insurance Enrollment/Change SFN 53504 which you need to complete to obtain dental insurance coverage effective {qu RequestedEnrollmentDate} under the NDPERS group dental plan. Please refer to the enclosed information concerning the coverage and monthly premium amount.

{x endblock}

{x when Health has “Y”}

Enclosed is a Retiree Group Health Insurance Application SFN 16277 which you need to complete to obtain health insurance coverage effective {qu RequestedEnrollmentDate} under the NDPERS group health plan, Dakota Retiree Plan. Please refer to the enclosed information concerning the coverage and monthly premium amount.

{x endblock}

{x when Vision has “Y”}

Enclosed is a Retiree Vision/Dental Insurance Enrollment/Change SFN 53504 which you need to complete to obtain Vision insurance coverage effective {qu RequestedEnrollmentDate} under the NDPERS group Vision plan. Please refer to the enclosed information concerning the coverage and monthly premium amount.

{x endblock}

{x when AutoDeduction has “Y”}

In order to have your premium deducted from your checking or savings account, the enclosed Authorization for Automatic Premium Deduction SFN 50134 must be completed and submitted by the 15th of the month prior to the effective date of coverage.

{x endblock}

{x when PremiumCheck has “Y”}

In order for coverage to be effective {qu DateOfCoverage}, all the request forms must be completed and returned together, as soon as possible, along with a check made out to NDPERS for the {qu EffectiveMonth} premium. Without this required payment, NDPERS will not be able to process your application.

{x endblock}

{x when Dental has “Y” }

{x quwhen YouOrYourSpouse has “0” }

You indicated that you are eligible for Medicare effective {qu EDate}. A photocopy of the applicable Medicare identification card(s) must accompany the application form for proof of coverage.

{x endblock}

{x quwhen YouOrYourSpouse has “1” }

You indicated that Your Spouse is eligible for Medicare effective {qu EDate}. A photocopy of the applicable Medicare identification card(s) must accompany the application form for proof of coverage.

{x endblock}

{x endblock}

{x when Vision has “Y”}

{x quwhen YouOrYourSpouse has “0” }

You indicated that you are eligible for Medicare effective {qu EDate}. A photocopy of the applicable Medicare identification card(s) must accompany the application form for proof of coverage.

{x endblock}

{x quwhen YouOrYourSpouse has “1” }

You indicated that your Spouse is eligible for Medicare effective {qu EDate}. A photocopy of the applicable Medicare identification card(s) must accompany the application form for proof of coverage.

{x endblock}

{x endblock}

{x when Health has “Y”}

{qu YouOrYourSpouse} must have both Part A and Part B of Medicare in effect to coincide with the effective date of coverage. Please provide this information in Part B of the application form. A photocopy of the applicable Medicare identification card(s) must accompany the application form for proof of coverage.

To enroll in the NDPERS Dakota Retiree Plan (a Medicare carve out policy) including NDPERS prescription drug coverage, you must complete and return the enclosed Medicare Application SFN 59562 application and the Group MedicareBlue Rx application to NDPERS. When you are enrolled onto the policy you will receive an identification card for the Dakota Retiree Plan, an identification card for the MedicareBlue Rx coverage and a Certificate of Insurance handbook explaining the benefits.

{x endblock}

In addition to the application, the enclosed Employer Verification of Insurance Coverage SFN 53621 must be by he employer administering your insurance plan. Without this form, we cannot process your application for insurance coverage.

**Please return all forms together; please do not send separately.** Enclosed is a self-addressed envelope for your convenience in returning the required forms to our office. Your forms must be received by the 10th of {qu MonthPrior} in order for your coverage to be effective {qu RequestedEnrollmentDate}.

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

Sincerely,

NDPERS Benefits Division

Enclosure - Employer Verification of Insurance Coverage SFN 53621

{tmp SFN-53621}

{x when Dental has “Y”}

Retiree Dental Insurance Enrollment/Change SFN 53504

{tmp SFN-53504}

{x endblock}

{ x when Health has “Y”}

Retiree Group Health Insurance Application SFN

{tmp SFN-16277}

{x endblock}

{x when Vision has “Y”}

Retiree Vision Insurance Enrollment/Change SFN 53505

{tmp SFN-53505}

{x endblock}

{x when AutoDeduction has “Y”}

Authorization for Automatic Premium Deduction SFN 50134

{tmp SFN-50134}

{x endblock}