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| **53504-****{stdMbrPERSLinkID}**   |  |  | | --- | --- | | {SFNLogo} | **RETIREE VISION/DENTAL INSURANCE ENROLLMENT, CHANGE, OR CANCEL**  NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  SFN 53504 (Rev. 12-2017)  {SFNAddress} |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | PART A MEMBER INFORMATION | | | | | | | | | | | Member Name (Last, First, Middle) {stdMbrFullNameLFM} | | | | | NDPERS Member ID {stdMbrPERSLinkID} | | | | | | Last Four Digits of Social Security Number **{stdMbrLastFourDigitsOfSSN}** | | | | | Date of Birth (mm/dd/yyyy) {stdMbrDateOfBirth} | | | | | | Spouse Name (Last, First, Middle) | | | | | | | | | | | Address | | City | | | | State | | ZIP Code | | | Daytime Telephone Number | | | | | | | | | | | **PART B Level of Coverage – CHOOSE ONE** | | | | | | | | | | | **Vision** | | | **Dental** | | | | | | | | I **decline/cancel** vision insurance coverage at this time  I elect vision insurance coverage:  Retiree Only  Retiree + Spouse  Retiree + Child(ren)  Retiree + Family | | | I **decline**/cancel dental insurance coverage at this time  I elect dental insurance coverage:  Retiree Only  Retiree + Spouse  Retiree + Child(ren)  Retiree + Family | | | | | | | | **PART C EFFECTIVE DATE & REASON** | | | | | | | | | | | Effective Date of Change (mm/dd/yyyy) | | | | | | | | | | | **Change Reason**  New Coverage (Select a Reason): New Retiree Medicare Eligible Surviving Spouse  Marriage (Date of Marriage \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_)  Loss of Other Coverage (Attach a Certificate of Creditable Coverage or Employer Verification of Insurance Coverage SFN 53621)  Transfer from existing policy (COBRA Ending, Non Medicare)  Remove Dependent/Spouse  Add Dependent/Spouse:  Is this an adult child? No Yes. Please answer the following questions.  Is adult child eligible to enroll under their own or spouse’s employer insurance plan? No Yes  Is adult child disabled? No Yes | | | | | | | | | | | **PART D DEPENDENT INFORMATION** | | | | | | | | | | | List all family members to be covered under the plan, other than yourself:   1. Indicate dependent’s address below name if address is different from yours. 2. For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild. 3. For Marital Status, enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed 4. 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. 5. If you are adding a grandchild, a Grandchild Eligibility Verification SFN 60983 must be submitted also, along with a copy of the child’s birth certificate.   \*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. | | | | | | | | | | | Last Name First Name Middle Name | Relationship | | | Gender | | Date  of Birth | Marital Status | | Social Security Number\* | |  | Spouse | | |  | |  |  | |  | |  |  | | |  | |  |  | |  | |  |  | | |  | |  |  | |  | |

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| RETIREE VISION/DENTAL INSURANCE ENROLLMENT/CHANGE  SFN 53504 (REV. 12-2017) Page 2   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **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)? 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/yyyy) | 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   |  | | --- | | If 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 | | | | | | | | | PART F PAYMENT METHOD | | | | | | | | | If you are drawing a pension from a NDPERS defined benefit plan (NDPERS/NDHPRS), the Teacher’s Fund for Retirement (TFFR), or the Job Service Retirement Plan, you can have your health insurance premium deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.  If you are drawing a pension from TIAA or the NDPERS Defined Contribution Plan or you are an ex-legislator, your health insurance premiums must be withheld from a bank account.  **CANCELLATION POLICY**  To cancel NDPERS group insurance coverage, a written request must be submitted. The request must provide the contract holder’s name, last four digits of social security number, NDPERS Member Id and effective date. NDPERS must receive a cancellation request by the end of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy. | | | | | | | | | RETIREMENT GROUP NDPERS/NDHPRS  TFFR  Job Service  TIAA  NDPERS Defined Contribution  Ex-Legislator  Alternate Retirement System | | | | PAYMENT OPTION – MUST SELECT ONE Deduct from pension check (Option only available for NDPERS/NDHPRS, TFFR, Job Service)  Withhold from bank account (Complete SFN 50134) | | | | | **PART G MEMBER AUTHORIZATION** | | | | | | | | | To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime. I understand my coverage begins on the effective date assigned by the carrier. If canceling coverage, I understand I will be responsible to request reimbursement from RHIC vendor for my retiree health insurance credit, if any.  I have read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans insured based on this application. | | | | | | | | | Signature of Applicant | | | | | | | Date Signed | |