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| **53799-****{stdMbrPERSLinkID}**   |  |  | | --- | --- | | {SFNLogo} | **RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)**  NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  SFN 53799 (Rev. 06-2015)  {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 NDPERS GROUP HEALTH INSURANCE** | | | | Do you wish to continue your current coverage in the NDPERS Group Health Insurance Plan through  COBRA Continuation?  No  Yes  If Yes at:  Current Level of Coverage; indicate level of coverage: Single Family  Reduced Level of Coverage (Self Only) | | | | Employees terminating employment, or otherwise losing eligibility, may continue their NDPERS Group Health Coverage at their own expense for a maximum of 18 months subject to the following:   1. You must be a member of the plan at time of loss of eligibility. 2. Your spouse or any other dependent(s) applying for this continuation coverage must be a member of the plan at time of loss of eligibility. 3. You must complete and submit this election form to NDPERS within 60 days from your last date of coverage.   If you do not choose continuation coverage, your group health coverage will end on the last day of the month for which premiums were paid. | | | | **PART C Payment Method** | | | | **DO NOT SEND MONEY WITH THIS FORM.** If a payment method is not elected, you will be billed for the premium due. NDPERS bills the 20th of each month for the following month's coverage. Your payment is due the 1st of the month. Failure to remit your premium by the due date will result in loss of health coverage.  **CANCELLATION POLICY**  To cancel NDPERS health coverage, a written request must be submitted. The request must provide the contract holder’s name, social security number 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-CREF  NDPERS DEFINED CONTRIBUTION  EX-LEGISLATOR | PAYMENT OPTION – MUST SELECT ONE Deduct from pension check  Withhold from bank account (Complete SFN 50134)  Withhold from bank account (Complete SFN 50134) | | | **PART D Member Authorization** | | | | 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 Member Date | | | |

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| RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA) SFN 53799 (Rev.06-2015) Page 2 PART A MEMBER INFORMATION   For member identification, complete all requested information.  **PART B NDPERS GROUP HEALTH INSURANCE**  If continuing coverage, indicate the level of coverage. If continuing insurance, but a reduced level of coverage then a “Retiree Group Health Insurance Application SFN 16277” must accompany this application.  **PART C Payment Method**  If continuing coverage, indicate which retirement group you are receiving benefits from and your method of payment.  **PART D Member Authorization**  You must sign and date this form for it to be valid. |