60036

Clear Form

HEALTH INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM SFN 60036 (10-2026)

2027 ACA Annual Enrollment

PART A MEMBER INFORMATION

Name (Last, First, Middle)		NDPERS Member ID
Last Four Digits of SSN	Date of Birth (mm/dd/yyyy)	Home Phone
Email		Cell Phone
Employer		Work Phone
Active in the Military? ☐ No ☐ Yes		

PART B INSURANCE ELECTION

Date of Change (mm/dd/yyyy) _____

Actual effective date of coverage will be determined by NDPERS based on plan provisions.

SECTION 1 Reason for Change

☐ New Coverage (I do not have existing coverage)
☐ ACA Temporary **(Employer Complete Part E)**
☐ Remove Dependent*
☐ Change HSA **(Complete Section 2)**
☐ Cancel Coverage (Skip to Part E for signature and date)
☐ Loss of Other Health Coverage (Attach a Certificate of Creditable Coverage)
☐ Transfer from existing NDPERS policy Current policyholder name & PERSLink ID: _____
☐ Add Dependent/Spouse: Is this an adult child? ☐ No ☐ Yes, If yes, answer the following question
Is adult child Disabled? ☐ No ☐ Yes, If yes, complete [SFN 58556] and [SFN 58798].

☐ Annual Enrollment
☐ Employment Status Change
☐ Leave of Absence/LOA or FMLA

SECTION 2 Type of Coverage (Choose ONE option)

☐ **PPO/Basic Health Plan**

PPO/Basic Health Plan Authorization: By signing this application I represent that I am joining the PPO/Basic Health Plan. I acknowledge I have had the opportunity to review the terms and conditions relating to participation in the PPO/Basic Health Plan.

☐ **High Deductible Health Plan/Health Savings Account (HDHP/HSA)** This option is available only to permanent employees of state agencies, the university system, and district health units.

HDHP/HSA Authorization: By signing this application I represent that: (1) I am joining a HDHP/HSA; (2) I will not be covered by any other health plan that is not a HDHP (including my spouse's general-purpose health care Flexible Spending Account, which is a non-HDHP) for the upcoming plan year or enrolled in Medicare; I have not enrolled in my employers general-purpose health care Flexible Spending Account for the upcoming plan year and (3) I cannot be claimed as a dependent on another person's tax return. I understand that a HSA will be established on my behalf. I acknowledge I have had an opportunity to review the terms and conditions relating to participation in the HDHP/HSA.

Would you like to contribute to an HSA on a pre-tax basis? ☐ No ☐ Yes

Level of Coverage	2026 Limit	2027 Limit
Single HDHP Coverage:	$4,400	$4,500
Family HDHP Coverage:	$8,750	$9,000
Age 55+ Catchup:	$1,000	$1,000

The HSA limits include all contributions (both employee & employer paid) for the calendar year. I understand that If I exceed the annual limits, it will be my responsibility to request a refund from the HSA administrator or be subject to federal excise tax.

If my employer allows pre-tax payroll deductions to my Health Savings Account, I elect to defer a monthly amount of: $_____

I understand that I may modify my election at any time throughout the year as long as applicable payroll timelines are followed.

I understand that if I am joining the HDHP due to annual enrollment and currently participate in my employer's Flex Medical Spending Account (MSA), my deduction to my HSA will begin no sooner than February and may be delayed until April if my MSA is not exhausted as of December 31. I also understand that if this is the case, the amount I may defer annually to my HSA will be prorated based on the limits and the number of months eligible.

Section 2 Signature for the HDHP/HSA Plan

Member's Signature (Electronic signatures not accepted.)	Date

SECTION 3 Level Of Coverage for Plan

☐ Single Coverage (Self Only)
☐ Family Coverage (Self & Spouse OR Self and Eligible Children OR Self, Spouse, Eligible Children

PART C DEPENDENT INFORMATION

List all family members to be covered under the plan, other than yourself:

a. Indicate dependent's address below name if address is different from yours.
b. Relationship: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
c. If you are adding a grandchild, submit **Grandchild Eligibility Verification [SFN 60983] and copy of the child's birth certificate**.

If the social security number is unknown at time of application, you may still submit the application, but will need to follow-up with this information once received/known.

Dependents to be listed on next page.

Spouse Name (last, first middle)*		Relationship Spouse	Gender
Date of Birth	SSN**	Marital Status	Court Ordered Coverage N/A
Dependent Name (last, first middle)*		Relationship	Gender
Date of Birth	SSN**	Marital Status	Court Ordered Coverage ☐ Yes ☐ No
Dependent Name (last, first middle)*		Relationship	Gender
Date of Birth	SSN**	Marital Status	Court Ordered Coverage ☐ Yes ☐ No
Dependent Name (last, first middle)*		Relationship	Gender
Date of Birth	SSN**	Marital Status	Court Ordered Coverage ☐ Yes ☐ No
Dependent Name (last, first middle)*		Relationship	Gender
Date of Birth	SSN**	Marital Status	Court Ordered Coverage ☐ Yes ☐ No
Dependent Name (last, first middle)*		Relationship	Gender
Date of Birth	SSN**	Marital Status	Court Ordered Coverage ☐ Yes ☐ No

** If address is different than subscriber, indicate address under name*

*** 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.*

PART D EMPLOYER CERTIFICATION OF ACA ELIGIBLE TEMPORARY EMPLOYEE

I certify that this employee meets the definition of a full-time employee under the Affordable Care Act and as such, is being offered coverage.

☐ **Monthly Measurement**
Date of New Hire (mm/dd/yyyy) _____
Date of Change in Position/Increase in Hours (mm/dd/yyyy) _____

☐ **Look-back Measurement**
The current measurement period used by the employer is From _____To _____

This information is required for NDPERS to determine enrollment eligibility.

Member's Signature (Electronic signatures not accepted.)	Date

See next page for Member Authorization and Signature.

PART E MEMBER AUTHORIZATION

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (front and back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively cancelling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

- I understand members are subject to limitations and exclusions outlined in the relevant Benefit Plan/Policy.
- I understand that in the event the group through which I am enrolled elects to terminate, the Insurance Carrier has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.
- I understand conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with the Insurance Carrier and has enrolled as a group with another Insurance Carrier.
- I understand, in the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit to NDPERS.
- I acknowledge that the Summary of Benefits and Coverage and other related plan information is available on the NDPERS website at www.ndpers.nd.gov.

Member's Signature (Electronic signatures not accepted.)	Date