(Rev. 01-2025)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

TRANSFER FORMS CHECKLIST

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53706

NOTICE OF TRANSFER

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53706 (Rev. 05-2023)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A MEMBER INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)

PART B CURRENT EMPLOYER

Organization Name		NDPERS Organization ID
Last Date of Service with Current Agency	Date of Last Regular Paycheck	Last Month of Reported Retirement Contributions
Last Month Insurance Premium(s) paid by your agency/or this employee (mm/yyyy)	Projected Hours of Sick Leave To Date of Transfer (must complete SFN 53404 to "bank" rejected hours)	

PART C CURRENT PLAN INFORMATION (Check yes or no for all NDPERS plans the employee is currently participating in)

Defined Benefit Plan	☐No ☐Yes	
Defined Contribution Plan	☐No ☐Yes	
☐Deferred Comp (457) ☐Other 457/403(b)	☐No ☐Yes	
	If Yes, Provider(s) If more than one provider, attach a detailed memo	If Yes, Monthly Deduction $
Group Health Insurance	☐No ☐Yes, select ☐Single ☐Family ☐PPO ☐HDHP	
Group Life Insurance	☐No ☐Yes, select	☐$12,000 Basic Life ☐Supplemental $_____.00 ☐Dependent $_____.00 ☐Spouse Supplemental $_____.00
Group Dental Insurance	☐No ☐Yes, select	☐Individual Only ☐Individual & Spouse ☐Individual & Child(ren) ☐Family
Group Vision Insurance	☐No ☐Yes, select	☐Individual Only ☐Individual & Spouse ☐Individual & Child(ren) ☐Family
FlexComp Plan	☐No ☐Yes	
	☐If Yes, Medical Spending Annual Deduction $	☐If Yes, Dependent Care Annual Deduction $

PART D AUTHORIZATION OF CURRENT AUTHORIZED AGENT

I certify that the above information is true and correct.

Authorized Agent Signature (Electronic Signature will not be accepted)	Telephone Number	Date of Signature

PART E NEW EMPLOYER

Organization Name	NDPERS Organization ID
First Day of Service with New Agency	Date of First Regular Paycheck
New Job Classification ☐Classified State ☐Non-Classified State ☐Non-State ☐State University System ☐TIAA ☐NDTFFR ☐Judge ☐Peace Officer ☐Correctional Officer ☐Firefighter ☐Elected Official ☐Appointed Official	
Employment Type ☐Permanent ☐Temporary	Status ☐Contributing ☐Non-Contributing
Seasonal ☐6 Months ☐9 Months ☐10 Months ☐11 Months	Hourly ☐No ☐Yes

PART F AUTHORIZATION OF NEW AUTHORIZED AGENT

I certify that the above information is true and correct.

Authorized Agent Signature (Electronic Signature will not be accepted)	Telephone Number	Date of Signature

INSTRUCTIONS

Often employees will terminate their position with an employer participating in NDPERS and take a job with another employer who is also participating in NDPERS. Therefore, the employee's membership is transferred to the new employer and membership IS NOT terminated unless the new employer does not offer or is not eligible for a particular NDPERS plan.

PART A MEMBER INFORMATION

For member identification, please provide all requested information.

PART B CURRENT EMPLOYER

An NDPERS Transfer Guide and Forms must be given to the employee to complete. **Completed forms must accompany the Notice of Transfer SFN 53706.**

Indicate the current employer's name and NDPERS assigned organization ID. Indicate the last day of employment, the last regular paycheck issued to the employee, and the last month retirement contributions will be reported.

Indicate last month insurance premiums will be paid by your agency/employee.

Indicate the projected accumulated unused sick leave at the date of transfer.

PART C CURRENT PLAN INFORMATION

Check the appropriate box on the right side for all NDPERS plans. If the employee does not participate in a plan, check the NO box. If the employee does currently participate, check the YES box and complete all applicable boxes following, if any.

PART D AUTHORIZATION OF AUTHORIZED AGENT

The current agency's designated NDPERS authorized agent must sign and date this form.

PART E NEW EMPLOYER

This form should be forwarded to the new employer. The new employer should indicate the organization name and NDPERS ID; as well as the first day of employment and the employee's first regular paycheck.

The new employer should transfer any eligible plan participation as indicated in Part C with NO change in the levels of coverage.

Any plans the employee currently participates in but not offered or eligible through new employment will be terminated.

Any plans the employee currently does not participate in but now is offered or eligible through new employment, the employer must enroll as a new employee. See your NDPERS Employer's Guide for instructions for enrolling a new employee.

PART F AUTHORIZATION OF AUTHORIZED AGENT

The new agency's designated NDPERS authorized agent must sign and date this form.

53404

TRANSFER OF UNUSED SICK LEAVE VERIFICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53404 (Rev. 08-2021)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A MEMBER INFORMATION

Member Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)

PART B MEMBER AUTHORIZATION

I authorize the exchange of unused sick leave information between my Former Employer, New Employer, and the North Dakota Public Employees Retirement System.

I understand that a completed "Transfer of Unused Sick Leave Verification SFN 53404" MUST be on file at NDPERS **within 60 days from the date I leave employment with my former employer**.]

I understand that if I fail to submit this form to NDPERS upon employment transfer **within the 60 days**, any unused sick leave accumulated with my previous employer will be forfeited. I will no longer be eligible to purchase these unused sick leave hours and convert to service credit at a later date when I terminate NDPERS employment.

I understand that upon my termination of employment, I will have the opportunity to convert my unused sick leave to service credit according the North Dakota Administrative Code Chapter 71-02-03-06.

Member's Signature (Electronic Signatures will not be accepted)	Date of Signature

PART C FORMER EMPLOYER VERIFICATION

Organization Name	NDPERS Organization ID
Total number of hours of unused sick leave at time of employment transfer	
Signature of Authorized Agent (Electronic Signatures will not be accepted)	Date of Signature

PART D NEW EMPLOYER VERIFICATION

Organization Name		NDPERS Organization ID
Total number of hours of unused sick leave **accepted**	Total number of hours of unused sick leave **rejected**	
Signature of Authorized Agent (Electronic Signatures will not be accepted)		Date of Signature

INSTRUCTIONS

PART A MEMBER INFORMATION

For member identification, please provide all requested information.

PART B MEMBER AUTHORIZATION

Member must read authorization, provide signature and date. This will authorize the information to be exchanged between employers and NDPERS. Once signed, member should forward the form to their former employer for completion.

PART C FORMER EMPLOYER VERIFICATION

Member's former employer must complete all information requested in Part C for the section to be valid. Once completed, former employer should forward the form to the new employer for completion.

PART D NEW EMPLOYER VERIFICATION

Member's new employer must complete all information requested in Part D for the section to be valid. Once sections A-D are completed, the form should be forwarded to NDPERS for processing. Upon receipt of a valid form at NDPERS, the hours of unused sick leave rejected by the new employer will be entered into the PERSLink system. Only documented hours at NDPERS will be eligible for purchase, along with any additional accumulated sick leave hours, when the member terminates eligible NDPERS employment at a future date.

60036

HEALTH INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 60036 (Rev. 03-2024)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A MEMBER IDENTIFICATION

Employee Name (Last, First, Middle)		NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)	Daytime Telephone Number
Organization Name		NDPERS Organization ID
Preferred Email Address	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)
☐Annual Enrollment
☐ACA Temporary **(Employer Complete Part E)**
☐Cancel Coverage
☐Loss of Other Coverage-Complete Part D (Must include Certificate of Creditable Coverage)

☐Transfer Employment

From	To

☐Transfer from existing NDPERS policy. Current policyholder name & PERSLink ID: _____
☐Return from Leave of Absence (LOA)
☐Change HSA (Complete Section 2)

☐Remove Dependent
☐Add Dependent/Spouse: Is this an adult child? ☐No ☐Yes If yes, please answer the following question.
Is adult child Disabled? ☐No ☐Yes If yes, complete SFN 58556 and SFN 58798.

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

Health Savings Account (HSA) Annual Maximum:

	2024
Single HDHP Coverage:	$4,150
Family HDHP Coverage:	$8,300
Age 55+ Catchup:	$1,000

HDHP/HSA election continued on the next page

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 for the HDHP/HSA Plan (Electronic signature is not accepted)	Date of Signature

Section 3 Level Of Coverage for Plan

☐ Single Coverage (Self Only)
☐ Family Coverage (Self and Spouse OR Self and Eligible Child(ren) OR Self, Spouse, Eligible Child(ren)

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.

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.

*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.

Dependent Name (last, first, middle) If address is different than subscriber, indicate address under name	Relationship	Gender	Date of Birth	Social Security Number	Marital Status	Court Ordered Coverage	
						No	Yes
	Spouse					N/A	
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

Continue to page 3

PART D OTHER HEALTH COVERAGE INFORMATION

If you are newly enrolling or updating your health insurance due to loss of coverage, this section must be completed. Attach a Certificate(s) of Coverage or other documentation from your insurance company showing the coverage end dates and individuals insured. **Failure to provide documentation may affect eligibility to enroll/update your insurance.**

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.**

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 - Explain why:

PART E 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.

Check appropriate method of determination

☐ **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.

Authorized Agent's Signature (Electronic signature is not accepted)	Date of Signature

Member Authorization on next page

PART F 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 https://www.ndpers.nd.gov/.

Please retain a copy of this Application for your records

Member's Signature (Electronic signature is not accepted)	Date of Signature

14120

Clear Form

CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 14120 (Rev. 04-2024)

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A APPLICANT INFORMATION

Name (Last, First, Middle)		Date of Birth		Applicant NDPERS Member ID (if known)
Last Four Digits of Social Security Number	Address	City	State	ZIP Code
Applicant Gender ☐ Male ☐ Female	Applicant's Home/Cell Number	Relationship to Current Contract Holder ☐ Self ☐ Spouse/Dependent		
Home/Personal Email Address				
Name of current contract holder (Last, First, Middle)				NDPERS Member ID

PART B EFFECTIVE DATE OF CHANGE

Change Effective Date (first of month after loss of active group coverage): _____
Actual effective date of coverage will be determined by NDPERS based on plan provisions.

PART C QUALIFYING COBRA EVENT/REASON FOR CHANGE

☐ Termination of current contract holder
☐ Divorce from current contract holder
☐ Death of current contract holder
☐ Marriage
☐ Attained Age 26
☐ Contract holder entitled to Medicare
☐ Remove Dependent
☐ Cancel COBRA (indicate plan(s) below)
☐ ACA ineligibility

Select the coverage(s) to be continued and check level of coverage.

☐ Health: ☐ Self Only ☐ Family ☐ Decline/Cancel

☐ Dental: ☐ Self Only ☐ Family ☐ Applicant & Spouse ☐ Applicant & Child(ren) ☐ Decline/Cancel

☐ Vision: ☐ Self Only ☐ Family ☐ Applicant & Spouse ☐ Applicant & Child(ren) ☐ Decline/Cancel

List all eligible covered individuals for the plan(s) listed above. Attach separate sheet if more room is needed.

***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.

Name (Last, First, Middle)	Relationship to Applicant	Gender	Date of Birth	Social Security Number*
	Self			

PART D PAYMENT METHOD

If a payment method is not selected, it will be your responsibility to submit payment by the 1st of each month. NDPERS does not direct bill for premiums. **Failure to remit your premium by the due date of the 1st of the month will result in loss of COBRA continuation coverage.**

NOTE: Your COBRA continuation coverage will not be in effect until premiums due are paid up to date or the bank account information is provided below. Members have 45 days from when NDPERS receives the election to remit COBRA payment to NDPERS.

NDPERS requires that the same bank account be used for all insurance premiums with that same payment method.

☐ Withhold from bank account. Complete bank information below.

Please write clearly and verify information for accuracy. Form will be returned if information provided is illegible.

Financial Institution Name	Financial Institution Routing Number (must be 9 digits)

Telephone Number

Type of Account & Account Number

☐ Checking Account Number ☐ Savings Account Number

Attach a Voided Check Here for Checking Account (Optional).
Deposit slips will not be accepted.

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written request with member signature must be submitted. The request must provide the contract holder's name, last four digits of social security number or 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 made at the end of the month. NDPERS cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

PART E APPLICANT AUTHORIZATION

I have read this application in its entirety, including the back page, and certify the information is accurate and complete. I understand and agree that any false statements or omissions may constitute a fraudulent act or intentional misrepresentation and may void or retroactively cancel any benefit issued based on this application.

Signature of Applicant (Electronic Signatures will not be accepted)	Date

.

PART A APPLICANT INFORMATION

For applicant identification, please provide all requested information.

PART B EFFECTIVE DATE OF CHANGE

- Indicate the qualifying event date or requested change effective date (actual effective date of coverage will be determined by NDPERS based on plan provisions).

PART C QUALIFYING COBRA EVENT/REASON FOR CHANGE

1. Check the box that describes the event that qualifies you for continuation coverage.

2. Indicate the group insurance plan(s) you are electing for COBRA continuation coverage.

3. Check the level of coverage. If you are not applying for the coverage, check the decline/cancel box.

4. List all covered individuals, including yourself. You may elect COBRA continuation coverage for only those family members that were covered on the plan at the time of the qualifying event.

PART D PAYMENT METHOD

Withhold from bank account: You must complete the banking information.

If a payment option is not selected, you will be required to submit premium by the 1st of each month. You will not receive a billing from NDPERS. Your COBRA continuation coverage will not be effective until the initial premium payment is received. **Failure to remit your premium by the due date of the 1st of the month will result in loss of insurance coverage.**

NDPERS requires that the same bank account be used for all insurance premiums with that same payment method.

PART E APPLICANT AUTHORIZATION

Employees terminating employment, or individuals otherwise losing eligibility may continue their NDPERS Group Health Coverage at their own expense 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 COBRA continuation coverage must be a member of the plan at the 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.
4. There must not be a lapse in coverage, i.e. premiums must be paid to ensure continuous coverage.

If you do not choose continuation coverage, your group health insurance coverage will end on the last day of the month for which premiums were paid.

You must sign and date this form for it to be valid. Electronic signatures will not be accepted.

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS

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58792

Clear Form

DENTAL/VISION INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58792 (Rev. 03-2024)

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(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A MEMBER IDENTIFICATION

Employee Name (Last, First, Middle)		NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth	Daytime Telephone Number
Organization Name		NDPERS Organization ID

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)
☐ Annual Enrollment
☐ Cancel Dental Coverage (if eligible)
☐ Cancel Vision Coverage (if eligible)
☐ Remove Dependent*
☐ Leave of Absence/LOA or FMLA
☐ Add Dependent/Spouse: Is this an adult child? ☐ No ☐ Yes, If yes, please answer the following question
Is adult child Disabled? ☐ No ☐ Yes, If yes, complete SFN 58556 and SFN 58798.

☐ Loss of Other Coverage (Attach a Certificate of Creditable Coverage)
☐ Transfer Employment:
from _____ to _____
☐ Transfer from existing NDPERS policy Current policyholder name & PERSLink ID: _____

*A dependent can only be removed from the dental or vision insurances mid-year if due to ineligibility (divorce, death, or when a dependent child is no longer eligible).

Section 2 Level Of Coverage for Plan(s):

Both Insurance options below must be completed:

Dental Insurance:	☐ Emp. Only	☐ Emp.+Spouse	☐ Emp.+Child(ren)	☐ Emp.+Family	☐ Decline/Cancel
Vision Insurance:	☐ Emp. Only	☐ Emp.+Spouse	☐ Emp.+Child(ren)	☐ Emp.+Family	☐ Decline/Cancel

Section 3 Pre-Tax Payroll Deduction Election

Do not complete Section 3 if you are an employee with Higher Education or a District Health Unit that does not participate in the NDPERS FlexComp plan.

Your insurance premium can be a pre-tax payroll deduction. If you pre-tax an insurance premium, you may not change coverage during the plan year unless you experience an IRS Qualified Change of Status.

Do you wish to have your insurance premium deducted as a pre-tax payroll deduction? Dental Insurance ☐ No ☐ Yes
Vision Insurance ☐ No ☐ Yes

Continued to page 2

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.

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.

Dependent Name (last, first, middle) If address is different than subscriber, indicate address under name	Relationship	Gender	Date of Birth	Social Security Number	Marital Status	Court Ordered Coverage	Active Military
	Spouse					N/A	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes
						☐No ☐Yes	☐No ☐Yes

PART D 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 attach Certificate(s) of Coverage or other documentation from your insurance company. Failure to provide documentation may affect your eligibility**

Do you intend to keep your current policy(ies) in force after the effective date of this Application?

☐Yes ☐No

If no, why? Please specify plan:

_____

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

Continued to page 3

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 understand that by making this election, I will be required to participate in the plan for the current calendar year and may only be able to cancel coverage during a future annual enrollment or upon termination of my employment.
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 pages) 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 ndpers.nd.gov.

Please retain a copy of this Application for your records

_____ _____
Member's Signature (Electronic signatures will not be accepted) Date of Signature

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50134

AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 50134 (Rev. 03-2024)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A PARTICIPANT IDENTIFICATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)

PART B MEMBER AUTHORIZATION

NDPERS requires that the same bank account be used for all premiums with that payment method. I authorize the following insurance premium(s) to be withheld from the Financial Institution indicated in Part C of this authorization:

☐ Health & Prescription Drug Plan ☐ Life ☐ Dental ☐ Vision

This authorization will remain in effect until the member notifies NDPERS in writing to cancel it in such time as to afford NDPERS a reasonable opportunity to act on it. **The premium amount will be deducted from the bank account by the 5th (fifth) day of each month or the next working day if the 5th (fifth) is on a weekend or a holiday**. Your financial institution may charge an additional fee for this service.

I agree to the terms listed on this authorization**. I authorize NDPERS to update any other insurance premiums currently being withheld from another bank account with this new Financial Institution information, even if the insurance is not marked above.** Any insurances with an alternative method of payment (not withheld from a bank account) will remain the same unless marked above.

Member's Signature (Electronic Signature will not be accepted)	Date

PART C FINANCIAL INSTITUTION INFORMATION

Please write clearly and verify information for accuracy. Form will be returned if information provided is illegible.

Financial Institution Name	Financial Institution Routing Number (must be 9 digits)

Type of Account & Account Number

☐ Checking Account Number

☐ Savings Account Number

Attach a Voided Check Here for Checking Account (Optional).
Deposit slips will not be accepted.

IMPORTANT NOTICE - This form is to be used only for North Dakota Public Employees Retirement System Group Insurance Deductions. **THIS FORM ONLY AUTHORIZES DEDUCTIONS FROM YOUR ACCOUNT.**

INSTRUCTIONS AND CONDITIONS

If you wish to have your monthly insurance premiums deducted from your savings or checking account, you must complete this form to authorize this action. The North Dakota Public Employees Retirement System (NDPERS) requires that the same bank account be used for all premiums with this payment method. The financial institution may be any bank, savings bank, savings and loan association or similar institution, or Federal or State chartered credit union.

PART A PARTICIPANT IDENTIFICATION

For member identification, please provide all requested information.

PART B MEMBER AUTHORIZATION

Check the type of insurance premium(s) you are requesting to be withheld from your bank account. Any insurances currently set up to be withheld from a bank account will be updated to the new bank information provided even if not marked in this section. Sign and date the form.

PART C FINANCIAL INSTITUTION INFORMATION

You may attach a voided check if you select a checking account.

CANCELLATION INSTRUCTIONS

When entered in your record with the North Dakota Public Employees Retirement System, this authorization will remain in effect until canceled by written notice by you to the North Dakota Public Employees Retirement System, or in the event of your death. The financial organization should also be notified if you cancel this agreement.

The financial organization may cancel their agreement by providing you a written notice 30 days in advance of the cancellation date. You must advise the North Dakota Public Employees Retirement System if this authorization is canceled. The financial organization cannot cancel this authorization by advice to the North Dakota Public Employees Retirement System.

The form is due back in our office by the 15th of the month prior to the month the new account will take effect.

53803

LIFE INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53803 (Rev. 04-2023)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

Underwritten by Voya Financial (Carrier) Policy Number: 67389-7

PART A EMPLOYER/EMPLOYMENT STATUS

Organization Name	NDPERS Organization ID	Employment Status ☐ Active Full-Time ☐ Active Part-Time

This Change is due to: (Check all that apply)

☐ New Hire (Date of Hire_____/_____/_____) ☐ New Employer Group

☐ Annual Enrollment-Read below for Evidence of Insurability (EOI) requirements

☐ Decrease Coverage ☐ Marital Status Change (Date of Change _____/_____/_____)

☐ Birth/Adoption (Date of Change_____/_____/_____)

Effective Date

_____/01/20____

PART B EMPLOYEE INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last 4 Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Personal Email Address	Telephone Number

PART C EMPLOYEE COVERAGE

Basic Life ☒ Employee Only—Employer Provides $12,000 of Basic Life Coverage at no expense to you
(Temporary employees electing coverage are responsible for basic life premium)

Supplemental Life and AD&D Election: When you are first eligible for supplemental life coverage, you can elect up to the Guaranteed Issue (GI) Limit of $300,000 without evidence of insurability (EOI). You can request coverage above the GI Limit to a maximum of $600,000, but must submit EOI. You are subject to approval by the carrier for the amount above GI. During annual enrollment, you can increase your existing employee supplemental by up to a $25,000 increment without EOI up to the GI Limit. EOI must be completed for newly electing employee supplemental (only have Basic $12,000), increases larger than $25,000, or requests above the GI Limit and are subject to approval by the Carrier.

☐ I am applying for a TOTAL (include Basic Life in total) supplemental life coverage of $_____ (Increments of $5,000)

☐ Waive Additional Supplemental Life & AD&D coverage

PART D DEPENDENT COVERAGE

Supplemental Dependent Life Insurance Election: Only available if you elected Supplemental in Part C. When you are initially eligible for dependent coverage or during annual enrollment, you can elect it without providing evidence of insurability.

☐ $10,000 for eligible spouse and $10,000 for each eligible dependent child. **OR**
☐ $7,000 for eligible spouse and $7,000 for each eligible dependent child. **OR**
☐ $5,000 for eligible spouse and $5,000 for each eligible dependent child. **OR**
☐ $2,000 for eligible spouse and $2,000 for each eligible dependent child. **OR**
☐ Waive Supplemental Dependent Coverage

PART E SPOUSE COVERAGE

Supplemental Spouse Life Election: Only available if you elected dependent coverage in Part D. When you are initially eligible for supplemental spouse coverage, you can elect up to $100,000 in coverage without providing evidence of insurability. Total spouse coverage up to $300,000 is available if your spouse completes an Evidence of Insurability form (EOI) for approval by the Carrier. **Supplemental spouse coverage is limited to 50% of the employee's coverage amount.** Upon a qualifying event or annual enrollment, an Evidence of Insurability form (EOI) must be completed.

☐ **Total Amount of coverage** $_____ (Increments of $5,000)

Name	**Date of Birth(mm/dd/yyyy)**

☐ Waive Supplemental Spouse Coverage

PART F BENEFICIARY INFORMATION

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855

Part G AUTHORIZATION AND INSTRUCTIONS

I acknowledge I have read the authorization on page 2 of SFN 53803.

Employee's Signature (Electronic Signature will not be accepted)	Date

PART G AUTHORIZATION

READ THIS INFORMATION CAREFULLY AND SIGN THIS FORM ON PAGE 1 BEFORE SUBMITTING IT TO NDPERS.

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- 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, provided I am actively at work.
- I understand that evidence of insurability may be required for coverage to become effective.

INSTRUCTIONS

Part A Employer/Employment Status

Must be completed by your employer's authorized agent.

Part B Employee Information

For member identification, please provide all requested information.

Part C Employee Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage. Indicate the TOTAL amount of coverage you are requesting.

Part D Dependent Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.

Part E Spouse Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.

Part F Beneficiary Information

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855.
IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part G Authorization

You must sign and date this this form to be valid. Electronic Signature will not be accepted.

The Evidence of Insurability form is accessible on the NDPERS website under Active Members>Insurance Plans>Life Insurance>Forms: https://www.ndpers.nd.gov/forms/life-insurance-forms-active.

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53855

LIFE INSURANCE DESIGNATION OF BENEFICIARY

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53855 (Rev. 03-2024)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

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. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

PART A MEMBER INFORMATION

Policy Number
67389-7

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	
Effective Date	

PART B DESIGNATION OF BENEFICIARY

All beneficiary designations shall equal 100% of the benefit. If more than one person in a class (primary or contingent beneficiary) is named, individuals of that class will share equally in the benefits unless specific shares are designated. If the total share does not equal 100%, NDPERS will amend the designation in order to reach 100%. If an amendment is necessary, NDPERS will adjust by no more than one (1) percent and the additional percentage shall be credited to the eldest beneficiary.

Primary Beneficiary(ies) If person enter Last, First, Middle	Relationship	Gender	Social Security Number	Birth Date	% Share	Address
					Total must equal 100%	

Contingent/Secondary Beneficiary(ies) If person enter Last, First, Middle	Relationship	Gender	Social Security Number	Birth Date	% Share	Address
					Total must equal 100%	

PART C MEMBER AUTHORIZATION

I understand that this election revokes any previous life insurance beneficiary designations. I have read and understand the terms and conditions listed on page two (2) of this designation. I hereby certify that the information provided on this form is true and correct to the best of my knowledge.

Member's Signature (Electronic Signatures will not be accepted)	Date

Part A Member Information

Enter your name, NDPERS ID number, date of birth, last four digits of your Social Security Number, marital status, and effective date of change.

Part B Designation of Beneficiary

1. Use full legal name. (Example: “Anna May Smith,” not Mrs. John Smith”)

2. A member may designate contingent beneficiary(ies) who will receive benefits if the primary beneficiary(ies) predecease member**.**

3. All beneficiary designations shall equal 100% of the benefit. If more than one person in a class (primary or contingent beneficiary) is named, individuals of that class will share equally in the benefits unless specific shares are designated. If the benefit is being divided amongst multiple beneficiaries and the total share does not equal 100%, NDPERS shall amend the designations in order to reach the 100% in total, but in no circumstance will NDPERS amend the beneficiary designation by more than one (1) percent. If an amendment is necessary, the additional percentage shall be credited to the eldest beneficiary. The benefit will be distributed as directed by the designation. If a named beneficiary does not survive, the beneficiary’s share will be distributed among any surviving beneficiaries in the same proportion as the initial shares.

4. To file a death claim, a certified copy of the Death Certificate must be provided to NDPERS to process the claim.

5. Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established, or as allowed by law.

6. If an estate is named, specify whose estate such as: “Estate of the Insured.” Full name and address of the executor must be included.

TRUSTEE DESIGNATION:

1. Trustee under the last will and testament of the insured, or his/her successors in trust, PROVIDED, HOWEVER, that if no claim is made by the Trustee within one year from the date of death of the insured or if the insured shall die leaving no last will and testament containing the trust covering this policy, the proceeds shall be payable to the estate of the insured. Payment of the proceeds of this policy to said Trustee or successors in trust shall fully and finally discharge the Company from all liability.

2. “The _____Trust Company, trustee under written trust agreement date (month, date, year) _____, or its successor or successors in trust, and payment of the proceeds of this policy to said Trustee or successor or successors shall fully and finally discharge the Company from all liability.” Full name and address of trust administrator must be included.

IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part C Member Authorization

You must sign and date this section for this form to be valid.

CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53512 (Rev. 09-2021)

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A PARTICIPANT/QUALIFIED BENEFICIARY INFORMATION

Name (Last, First, Middle)	PeopleSoft Employee ID (Required)	NDPERS Member ID
Last Four Digits of Social Security Number		Date of Birth (mm/dd/yyyy)

PART B CONTINUATION OF COVERAGE ELECTION / WAIVER

If you elect Medical Spending Continuation coverage, it will be in effect to the end of the current plan year, or December 31.

Do you wish to continue your current participation in the NDPERS Flexcomp Plan Medical Spending Account? ☐ Yes ☐ No

☐ I wish to pre-pay the premium through the end of the plan year with pre-tax dollars deducted from my final pay checks.

☐ I will pay the premium plus a 2% administration fee with after-tax dollars through the remainder of the plan year.

PART C AUTHORIZATION OF APPLICANT

I have read the information in its entirety, **including the back page**, and agree to abide by the terms of the Plan Document. I understand that if I have elected to pre-pay the premium from my final paychecks, that NDPERS will contact my employer to notify them of my election and to discuss termination processing. I certify, under penalties of perjury, that the information submitted on this form is true, correct and complete.

Applicant's Signature (Electronic Signatures will not be accepted)	Date

Entitlement to COBRA Coverage

Under provisions of the Internal Revenue Service (IRS) COBRA regulations, you have the opportunity to extend your participation in the Medical Spending Account to the end of the current plan year.

The employer has the responsibility to notify NDPERS of a participant's death, termination, or reduction in hours of employment.

Qualified Beneficiaries Your spouse or dependent(s) may elect to continue coverage in a medical spending account under the following circumstances:

1. Participant's death.
2. Divorce or legal separation.
3. A dependent child ceases to be a "dependent child" under the group health plan.

If you elect COBRA continuation, your premium payment will be based on the annual election amount in existence at the time of the qualifying event.

Under the law, it is the responsibility of the person seeking continuation coverage to inform NDPERS of a divorce, legal separation or a child losing dependent status within 60 days of the date of the event. If you are interested in COBRA continuation coverage, contact NDPERS for more information.

Length of COBRA Coverage

You, your spouse or dependent(s), are eligible to receive continuation coverage until the end of the plan year, or December 31, in which the qualifying event occurred. If you have paid your premium through the end of the year on December 31 and have a balance in your account, you have the option to have eligible expenses incurred during the "grace period", from January 1 through March 15 of the new plan year, reimbursed from that remaining balance. You will have until April 30 to submit claims. Any amount remaining in your medical spending reimbursement account after the April 30 claims filing deadline is forfeited.

COBRA Coverage Premiums

Employees who elect COBRA continuation coverage are permitted to pre-tax the COBRA premium and pre-pay the premium through the end of the current plan year from their final paychecks.
To pay the premium with after-tax dollars throughout the plan year, submit the premium amount plus a two percent (2%) administrative fee by the first of each month. If you fail to pay the premium on time, your coverage will terminate on the last day of the month for which a contribution was received.

Continuation coverage under COBRA is provided subject to your eligibility. NDPERS reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

You will have 60 days from the date of this notice to inform NDPERS that you want continuation coverage.

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS OF THE DATE OF THIS NOTICE YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE

3803

Clear Form

457 DEFERRED COMPENSATION PLAN ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 3803 (Rev. 12-2024)

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A MEMBER INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Preferred phone number	Preferred email address
Organization Name	NDPERS Organization ID

PART B PROVIDER INFORMATION

Choose one: ☐ Empower Companion Plan ☐ Bravera ☐ Nationwide ☐ Bank of North Dakota

☐ Grandfathered State of ND 457 plan. Enter Provider Name:_____
* not available to newly enrolling members

SFN 3803 must be completed for each provider if participating with more than one provider.

Agent Name (no agent can be named for the Companion plan)	Agent Telephone Number and/or email

PART C

COMPLETE IF NEWLY ENROLLED AFTER DECEMBER 31, 2024 IN THE DEFINED CONTRIBUTION PLAN

☐ I am enrolled in the Defined Contribution Plan 2025 Tier 3. If applicable, I elect my employer match to be sent to the provider selected above.

Participant's Signature (Electronic Signature will not be accepted)	Date (Must be prior to the date on Part F)

PART D CHECK ALL THAT APPLY

☐ 1. New Application
☐ 2. Increase Deduction
☐ 3. Decrease Deduction
☐ 4. Suspend Deduction (Includes full-time to part-time)
☐ 5. Lump sum Sick & Annual Leave ☐ Exclude Regular Monthly Deduction
Required for lump sum sick and annual leave-Last Date of Employment
_____/_____/_____ (date required)
* contact your employer in order for your lump sum deduction to be entered correctly.

☐ 6. Age 50 or older: Annual Catch-up
☐ 7. Regular 3 Year Catch-up
☐ 8. Provider Change
☐ 9. Change in Agent only
☐ 10. USERRA Missed Contributions

PART E CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION

Must be completed if you checked 1, 2, 3,5, 6,7, or 10 in Part D

A. Annual Gross Pay $_____
B. Less Employer Retirement Contributions made under an IRC 414(h) arrangement (use most recent pay stub) $_____
C. Includable Compensation (subtract B from A) $_____
D. Maximum Annual Allowable Deduction:
D1. Lesser of 100% of Includable Compensation or annual maximum limit (see annual limits on back of form). Enter the lesser of D1 but not less than the minimum annual deduction of $300.00 ($25.00) per month $_____
E. Pay Period Deduction (D divided by number of pay periods in calendar year) $_____

PART F SALARY REDUCTION AUTHORIZATION

Must be completed if you checked 1, 2, 3,5, 6,7, or 10 in Part D

Authorization for deductions must be made in the month prior to the pay period in which the income is earned.

☐ I authorize my employer to reduce my salary.

Amount Per Pay Period (must be higher than $25/month) $	Pay Period Beginning Date **(Not Date Paid)** mm/dd/yyyy

(The signature date in Part G must be in the month prior to the pay period date entered here.)

With regard to this agreement, the Participant acknowledges the following:

- I understand that my salary will be reduced each pay period by the amount authorized above. The deduction cannot be changed or stopped without an authorized participant agreement form returned to payroll from NDPERS.
- I understand the accumulated deferred salary is credited to my account and is not available to me or my beneficiary(ies) until I separate from service, unless, I should experience an unforeseeable emergency and a distribution is approved by the NDPERS Board.
- I acknowledge that the Retirement Board makes no recommendation as to any provider and understand that the Retirement Board does not warrant or guarantee the investment performance of any provider.
- I understand that all compensation deferred under the Plan, and all earnings accruing thereof, shall be held for the exclusive benefit of myself or my Beneficiary, until such time as it is made available to me pursuant to the terms of the Plan.
- I understand that this agreement includes the beneficiary forms as executed with and maintained by my provider.
- I authorize NDPERS to contact my employer to confirm my last date of employment for any lump sum payout (#10 above), if not provided, and the North Dakota Office of Management and Budget, if necessary, to insure the authorized amount is withheld from my paycheck.

PART G PARTICIPANT AUTHORIZATION

I verify that the foregoing statements are true and correct to the best of my knowledge and belief and are subject to the laws and penalties governing any misrepresentations and fraud.

This form must be dated in the month prior to a lump Sum payout (Part D #5 or the date listed in Part F.)

Participant's Signature (Electronic Signature will <u>not</u> be accepted)	Date (Must be prior to the date on Part F)

ANNUAL LIMITS

Annual Limit for 2025:	$23,500
Age 50+ Limit for 2025:	$31,000
Regular 3 Year Catchup:	$47,000 Regular 3 Year Catchup must be within three (3) year **prior to the year in which you retire.**

PART A MEMBER INFORMATION

For member identification, please provide all requested information.

PART B PROVIDER INFORMATION

Eligible 457 Providers include Empower Companion Plan, Bravera, Nationwide and Bank of North Dakota.
If you have an account with a grandfathered State of ND 457 plan, please list the plan. Grandfathered plans are not available to newly enrolling members**.**

If you check 'New Application in Part C, you must first select and contact one of the eligible providers for the plan. The provider representative you select will assist you in completing the required forms to open an account.

PART C

ELIGIBILE FOR DEFINED CONTRIBUTION PLAN 2025 (TIER 3 DC 2025)

NDCC 54-52.6-01 defines an eligible employee who is first enrolled effective January 1, 2025, in the Defined Contribution Plan as having the same meaning as provided under section 54-52-02.15. According to 54-52.6-09, all eligible employees of a participating employer must be immediately enrolled in the NDPERS Defined Contribution Plan within the first month of employment.

Per NDCC 54-52-02.15, "eligible employee" means a permanent employee who meets the following:

1) is at least eighteen years of age;
2) becomes a participating member after December 31, 2024 and
3) is not eligible to participate in the law enforcement plan, judges' plan, highway patrol plan, teachers' fund for retirement plan, or alternative retirement plan established under section 15-10-17 for university system employees.

After December 31, 2024, under 54-52.6-02.1, eligible employees includes the following:

1) Temporary or Part-time employees within 180 days of beginning employment must complete the Agreement/Waiver of Participation for Optional Defined Contribution Retirement Plan SFN 54366.
2) Elected or appointed state officials enrolled for the first time, from and after the date that individual qualifies and takes office.
3) Nonstate appointed officials of participating employers within the first month of taking office.

Elected officials specifically of participating counties, at their individual option, may enroll within the first six months of their term.

The employee must sign and date this section.

Defined Contribution 2025 (Tier 3 DC 2025): participation in a NDPERS State of ND 457 Plan also allows up to a 3% match from my employer if election in the Defined Contribution Plan was not maximized within the first 30 days of employment.

Part D CHECK ALL THAT APPLY
Check the applicable box(s).

Box 5 lump sum payout - please indicate if your regular monthly deduction for that same month should be excluded. NDPERS requires that you also enter your last date worked or authorize NDPERS to contact your employer in order for your lump sum deduction to be entered correctly.
Box 7 Regular 3 Year Catch-up –457 Deferred Compensation Catch-up Worksheet SFN 51501 MUST accompany this form.
Box 8 Provider Change - YOU MUST complete 2 Participant Agreement forms: *One for the new provider & √ 'New Application' 2. One to stop contributions to old provider & √ 'Suspend Deduction.'
Box 9 Change in Agent only - Complete Part A, B & F of this form

Note: All Defined Benefit Retirement Plans - enrollment automatically maximizes retirement savings by vesting in the employer's contribution through Portability Enhancement Provision (PEP).

Defined Contribution (Tier 1 DC) or Defined Contribution 2020 (Tier 2 DC2020) - there is no matching, PEP or employer match.

Defined Contribution 2025 (Tier 1 DC2025) – there is a matching employer contribution, up to 3% (if not matched at 3% in the DC plan).

PART E CALCULATION OF MAXIMUM ALLOWABLE DEDUCTION
The minimum contribution is $25.00 per month. The maximum regular annual contribution limit is the lesser of 100% of annual compensation or the annual maximum limit indicated above.

PART F SALARY REDUCTION AUTHORIZATION
The IRS regulations require you to make your deferral election in the month prior to the month the salary is earned.

PART G PARTICIPANT AUTHORIZATION
Sign where indicated. If you completed Part E, your signature must be dated in the month prior to the month entered in that section.

Defined Benefit Plan and Defined Contribution Plan: The employee's signature in this section **will authorize** a reduction in the employee's monthly wage and contribution to a deferred compensation plan.