



AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION
 NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
 SFN 50134 (Rev. 06-2018)

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

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

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.

Member's Signature	Date
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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 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Telephone Number	
Type of Account & Account Number	
<input type="checkbox"/> Checking Account Number <input type="text"/>	<input type="checkbox"/> Savings Account Number <input type="text"/>

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 will deduct these premiums to the point you authorize. 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. 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 you want to begin your premium deduction