DENTAL/VISION INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58792 (Rev. 08-2020)

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

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
☐ Cancel Vision Coverage
☐ Remove Dependent
☐ Loss of Other Coverage
☐ Transfer Employment:
from _____ to _____
☐ Transfer from existing policy **(Complete Part D)**

☐ Add Dependent: Is this an adult child? ☐ No ☐ Yes, Please answer the following question.
Is adult child Disabled? ☐ No ☐ Yes

Section 2 Level Of Coverage for Plan(s):

Dental Insurance	**Vision Insurance**
☐ Single Coverage	☐ Single Coverage
☐ Employee and Spouse	☐ Employee and Spouse
☐ Employee and Child(ren)	☐ Employee and Child(ren)
☐ Employee and Family	☐ Employee and Family

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

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PART C DEPENDENT INFORMATION

1. List all family members to be covered under the plan **indicated in Part B, Section 2**, other than yourself.
   a. Indicate dependent's address below name if address is different from yours.
   b. For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
   c. For Marital Status, enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed
2. 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.

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 complete this section AND attach Certificate(s) of Coverage or other documentation from your insurance company. Failure to provide documentation may affect your eligibility.**

Plan**	Other Coverage Name & Phone Number	Policy Number	Policyholder (last, first, middle)	Date of Birth	Policy Coverage Dates (mm-dd-yy)	Name(s) of Person(s) Covered
					From: To:	
					From: To:	

****For Plan, indicate type of coverage -- Dental, or Vision**

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

Person's Name	Injury Date (MM-DD-YY)	Type of Injury	Company Providing Benefits & Phone Number

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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 Date of Signature