58792

Clear Form

DENTAL/VISION INSURANCE APPLICATION OR CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58792 (Rev. 03-2024)

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 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