14120

CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 14120 (Rev. 10-2022)

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Clear Form

PART A APPLICANT INFORMATION

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

PART B QUALIFYING COBRA EVENT/REASON FOR CHANGE

☐ Termination of current contract holder	☐ Marriage	☐ Remove Dependent
☐ Divorce from current contract holder	☐ Attained Age 26	☐ Cancel COBRA
☐ Death of current contract holder	☐ Contract holder entitled to Medicare	☐ ACA ineligibility

Change Effective Date: _____
Actual effective date of coverage will be determined by NDPERS based on plan provisions.

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

☐ Health Insurance:	☐ Self Only	☐ Family	☐ Waive		
☐ Dental Insurance:	☐ Self Only	☐ Family	☐ Applicant & Spouse	☐ Applicant & Child(ren)	☐ Waive
☐ Vision Insurance:	☐ Self Only	☐ Family	☐ Applicant & Spouse	☐ Applicant & Child(ren)	☐ Waive

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 Employee	Gender	Date of Birth	Social Security Number*
	Self			
	Spouse			

PART C PAYMENT METHOD

PAYMENT OPTION

☐ Withhold from bank account. Complete Authorization for Automatic Premium Deduction SFN 50134.

If a payment option is not elected, it will be your responsibility to submit payment by the 1st of the month. Your continuation coverage will not be effective until the initial premium payment is received. NDPERS does not bill for premium. **Failure to remit your premium by the due date will result in loss of insurance coverage.**

CANCELLATION POLICY

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

PART D 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

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PART A APPLICANT INFORMATION

For applicant identification, please provide all requested information.

PART B QUALIFYING COBRA EVENT/REASON FOR CHANGE

- Check the box that describes the event that qualifies you for continuation coverage.
- Indicate the qualifying event date or requested change effective date (actual effective date of coverage will be determined by NDPERS based on plan provisions).
- Indicate the group insurance plan(s) you are electing for continuation coverage.
- Check the level of coverage. If you are not applying for the coverage, check the waive box.
- List all covered individuals. You may elect continuation coverage for only those family members that were covered on the plan at the time of the qualifying event.

PART C PAYMENT METHOD

If you check withhold from bank account, you must complete an Authorization for Automatic Premium Deduction SFN 50134. If a payment option is not elected, you will be required submit premium by the 1st of each month. Your continuation coverage will not be effective until the initial premium payment is received. You will not receive a billing from NDPERS. **Failure to remit your premium by the due date will result in loss of insurance coverage.**

PART D 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 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.

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS