60711

ACKNOWLEDGEMENT OF OR DECLINE OFFER OF HEALTH INSURANCE COVERAGE
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 60711 (Rev. 12-2021)

Clear Form

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PART A EMPLOYEE IDENTIFICATION

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

PART B ACKNOWLEGEMENT OF OFFER OF HEALTH INSURANCE COVERAGE (FOR STATE EMPLOYEES COVERED UNDER NDPERS THROUGH SPOUSE OR PARENT)

☐ I understand that I am offered adequate and affordable coverage as a "full-time" employee as defined by the Affordable Care Act. I am already covered under the NDPERS health insurance through my spouse or parent. I understand that my coverage will remain through my spouse or parent unless my spouse or parent terminates employment or ceases to be an Eligible Employee, at which time I will have the opportunity to apply for coverage within 31 days of the event as an Eligible Employee.

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

PARTC DECLINE OFFER OF HEALTH INSURANCE COVERAGE

I understand that I am offered adequate and affordable coverage as a "full-time" employee as defined by the Affordable Care Act. I understand that the coverage is offered to me and my Eligible Dependents. I decline for one of the following (check applicable) reasons:

Please check the applicable box:

☐ I have coverage through my spouse's or parent's employer (non-NDPERS)
☐ I have other individual coverage (non-NDPERS)
☐ I have Medicare coverage
☐ Other:_____

I hereby decline health insurance coverage at this time. I understand that in declining this offer of health insurance coverage, I may not be eligible to apply for a federal tax subsidy through the Marketplace Exchanges. I fully understand that if I or my Eligible Dependents desire to be covered under my employer's insurance Benefit Plan in the future, I and my Eligible Dependents may have a Waiting Period for Preexisting Conditions and one of the following must apply:

1. If at the time I am declining coverage, it is because:
   a. I or my Eligible Dependents have other group insurance coverage, and that coverage is either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours) or employer contributions toward such coverage was terminated; or
   b. Coverage was under COBRA at the time I declined coverage and that coverage has been exhausted.

   Under (a.) and (b.) above, I must complete a membership application within 31 days after I lose my current coverage.

2. If I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may enroll myself and my Eligible Dependents, provided that I request enrollment within 31 days of marriage, birth, adoption or placement for adoption.

3. If I do not meet requirements under 1 or 2 above, I may apply as a Late Enrollee, Late Enrollees must request enrollment during the Enrollment Period.

Signature (Electronic Signature will not be accepted)	Date