53803

LIFE INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53803 (Rev. 04-2023)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
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Underwritten by Voya Financial (Carrier) Policy Number: 67389-7

PART A EMPLOYER/EMPLOYMENT STATUS

Organization Name	NDPERS Organization ID	Employment Status ☐ Active Full-Time ☐ Active Part-Time

This Change is due to: (Check all that apply)

☐ New Hire (Date of Hire_____/_____/_____) ☐ New Employer Group

☐ Annual Enrollment-Read below for Evidence of Insurability (EOI) requirements

☐ Decrease Coverage ☐ Marital Status Change (Date of Change _____/_____/_____)

☐ Birth/Adoption (Date of Change_____/_____/_____)

Effective Date

_____/01/20____

PART B EMPLOYEE INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last 4 Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Personal Email Address	Telephone Number

PART C EMPLOYEE COVERAGE

Basic Life ☒ Employee Only—Employer Provides $12,000 of Basic Life Coverage at no expense to you
(Temporary employees electing coverage are responsible for basic life premium)

Supplemental Life and AD&D Election: When you are first eligible for supplemental life coverage, you can elect up to the Guaranteed Issue (GI) Limit of $300,000 without evidence of insurability (EOI). You can request coverage above the GI Limit to a maximum of $600,000, but must submit EOI. You are subject to approval by the carrier for the amount above GI. During annual enrollment, you can increase your existing employee supplemental by up to a $25,000 increment without EOI up to the GI Limit. EOI must be completed for newly electing employee supplemental (only have Basic $12,000), increases larger than $25,000, or requests above the GI Limit and are subject to approval by the Carrier.

☐ I am applying for a TOTAL (include Basic Life in total) supplemental life coverage of $_____ (Increments of $5,000)

☐ Waive Additional Supplemental Life & AD&D coverage

PART D DEPENDENT COVERAGE

Supplemental Dependent Life Insurance Election: Only available if you elected Supplemental in Part C. When you are initially eligible for dependent coverage or during annual enrollment, you can elect it without providing evidence of insurability.

☐ $10,000 for eligible spouse and $10,000 for each eligible dependent child. **OR**
☐ $7,000 for eligible spouse and $7,000 for each eligible dependent child. **OR**
☐ $5,000 for eligible spouse and $5,000 for each eligible dependent child. **OR**
☐ $2,000 for eligible spouse and $2,000 for each eligible dependent child. **OR**
☐ Waive Supplemental Dependent Coverage

PART E SPOUSE COVERAGE

Supplemental Spouse Life Election: Only available if you elected dependent coverage in Part D. When you are initially eligible for supplemental spouse coverage, you can elect up to $100,000 in coverage without providing evidence of insurability. Total spouse coverage up to $300,000 is available if your spouse completes an Evidence of Insurability form (EOI) for approval by the Carrier. **Supplemental spouse coverage is limited to 50% of the employee's coverage amount.** Upon a qualifying event or annual enrollment, an Evidence of Insurability form (EOI) must be completed.

☐ **Total Amount of coverage** $_____ (Increments of $5,000)

Name	**Date of Birth(mm/dd/yyyy)**

☐ Waive Supplemental Spouse Coverage

PART F BENEFICIARY INFORMATION

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855

Part G AUTHORIZATION AND INSTRUCTIONS

I acknowledge I have read the authorization on page 2 of SFN 53803.

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

PART G AUTHORIZATION

READ THIS INFORMATION CAREFULLY AND SIGN THIS FORM ON PAGE 1 BEFORE SUBMITTING IT TO NDPERS.

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.
- I understand my coverage begins on the effective date assigned by the Carrier, provided I am actively at work.
- I understand that evidence of insurability may be required for coverage to become effective.

INSTRUCTIONS

Part A Employer/Employment Status

Must be completed by your employer's authorized agent.

Part B Employee Information

For member identification, please provide all requested information.

Part C Employee Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage. Indicate the TOTAL amount of coverage you are requesting.

Part D Dependent Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.

Part E Spouse Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had or elect to decrease your level of coverage.

Part F Beneficiary Information

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855.
IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part G Authorization

You must sign and date this this form to be valid. Electronic Signature will not be accepted.