59065

COBRA PREMIUM SUBSIDY ELECTION FORM

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 59065 (02-2022)

Clear Form

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 INFORMATION

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

PART B SUBSIDY ASSISTANCE ELIGIBILITY

If you are currently enrolled for COBRA continuation and wish to elect the premium subsidy, you must complete and return this form to NDPERS.

If you previously waived COBRA or your coverage was cancelled and you wish to apply for the premium subsidy, you must complete this form and the Continuation of Group Insurance Coverage (COBRA)-SFN 14120 and return them to NDPERS.

Upon receipt and verification of your eligibility by your previous employer, you will be sent a confirmation letter. If you are currently on COBRA continuation, your current billing arrangement will be suspended until the end of the subsidy period or your original COBRA period ends, whichever is first.

If you do not apply for the subsidy and/or COBRA continuation coverage within the 60-day election period, you will not be entitled to the subsidy or, if not currently enrolled, the continuation coverage.

PART C ELIGIBILITY DETERMINATION

Check the applicable response for each of the following (If you answer no to question 1, you are not considered an Assistance Eligible Individual and can discontinue the application):

1. Did you experience a reduction of hours or an involuntary loss of employment?
   ☐ Yes ☐ No
2. Are you or any eligible family members eligible for health insurance coverage under any employer plan?
   ☐ Yes ☐ No
3. Are/were you eligible for Medicare during the period for which you are requesting premium assistance?
   ☐ Yes ☐ No

PART D ELECTION FOR SUBSIDY ASSISTANCE

I elect to continue COBRA continuation coverage at the subsidized rate for the following plan(s). You may only elect those plans you and any eligible family members were enrolled in at the time of termination or reduction in hours.

☐ NDPERS Health Plan ☐ NDPERS Dental Plan ☐ NDPERS Vision Plan

PART E MEMBER CERTIFICATION

I make an election to exercise my right to American Rescue Plan premium assistance and attest that I meet the requirements for treatment as an Assistance Eligible Individual. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

_____ _____

Member Signature (Electronic signatures will not be accepted) Date of Signature

PART F NDPERS USE ONLY

This application is: ☐ Approved ☐ Denied **By**: _____

If denied, reason: _____

COBRA Effective Date: _____ Subsidy Effective Date: _____

COBRA End Date: _____ Subsidy End Date: _____

Org to Bill: _____

ORIGINAL TO NDPERS – RETAIN A COPY FOR YOUR RECORDS