16277

Clear Form

RETIREE GROUP HEALTH INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 16277 (Rev. 05-2025)

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

Member Name (Last, First, Middle)		NDPERS Member ID	
Last Four Digits of Social Security Number		Date of Birth (mm/dd/yyyy)	
Spouse Name (Last, First, Middle)		Member's Telephone Number (Daytime)	
Address	City	State	ZIP Code

ELIGIBLE RETIREMENT GROUP (select one)

☐ NDPERS ☐ NDHPRS ☐ Job Service ☐ TFFR ☐ TIAA ☐ Ex-Legislator
☐ NDPERS Defined Contribution ☐ Alternate Retirement System

PART B LEVEL OF COVERAGE – CHOOSE ONE

☐ I **decline** health insurance coverage at this time
☐ Single Coverage (Self Only)
☐ Family of 2 Coverage (Self and one other eligible family member)
☐ Family of 3 or More Coverage (Self and two or more eligible family members)

PART C EFFECTIVE DATE & REASON

Effective Date of Change (mm/dd/yyyy)

_____/_____/_____

Actual effective date of coverage will be determined by NDPERS based on plan provisions.

Change Reason (Select one of the options below)

☐ New Retiree
☐ Change Payment Method (complete Part F)
☐ Surviving Spouse
☐ Marriage (Date of Marriage _____/_____/_____)
☐ Loss of Other Coverage (Attach a Certificate of Creditable Coverage)
☐ Transfer from existing NDPERS policy. Current policyholder name & PERSLink ID: _____
☐ Remove Dependent/Spouse
☐ 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.

PART D 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.

Name (Last, First, Middle)	Relationship	Gender	Date of Birth	Marital Status	Social Security Number*
	Spouse				

PART E 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 complete this section AND attach Certificate(s) of Coverage. Failure to provide documentation may affect your eligibility.**

Other Coverage Name & Phone Number	Policy Number	Policyholder (last, first, middle)	Date of Birth	Policy Coverage Dates (mm/dd/yyyy)	Name(s) of Person(s) Covered
				From: To:	
				From: To:	

Do you intend to keep your current policy (ies) in force after the effective date of this Application?

☐Yes ☐No If no, why?

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

PART F PAYMENT METHOD

If you are drawing a pension from a NDPERS defined benefit plan (NDPERS or Job Service Retirement Plan) or the Teacher's Fund for Retirement (TFFR), your health insurance premium may be deducted from your pension check. If your pension check is not large enough, your health insurance premiums must be withheld from a bank account by completing the bank information section on the next page.

If you are drawing a pension from TIAA or the NDPERS Defined Contribution Plan or you are an ex-legislator, your health insurance premiums must be withheld from a bank account. Please complete the bank information section on the next page.

NDPERS does not direct bill for premiums. **Failure to remit your premium by the due date of the 1st of the month will result in loss of COBRA continuation coverage**.

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☐ Deduct from Pension Check* (only available for retirees of the following plans). Please indicate which retirement plan:
☐ NDPERS ☐ TFFR

☐ Withhold from bank account. Complete the information below. Please write clearly and verify information for accuracy. Form will be returned if information provided is illegible.

NDPERS requires that the same bank account be used for all insurance premiums with that same payment method. This authorization will remain in effect until the member notifies NDPERS in writing to cancel it in such time as to afford NDPERS a reasonable opportunity to act on it.

The premium amount will be deducted from the bank account by the 5th (fifth) day of each month or the next working day if the 5th (fifth) is on a weekend or a holiday. Your financial institution may charge an additional fee for this service.

I agree to the terms listed on this authorization. I authorize NDPERS to update any other insurance premiums currently being withheld from another bank account with this new Financial Institution information, even if I have not provided an updated payment method for that insurance. Any insurances with an alternative method of payment (not withheld from a bank account) will remain the same unless an alternative payment method is provided.

Financial Institution Name	Financial Institution Routing Number (must be 9 digits)
☐ Checking Account Number	☐ Savings Account Number

Attach a Voided Check Here for Checking Account (Optional).
Deposit slips will not be accepted.

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written cancellation request must be submitted by the end of the month prior to the effective date. The cancellation request must include the member's name, NDPERS member ID, last four digits of social security number, and effective date. Partial month or retroactive cancellations will not be accepted.

PART G MEMBER AUTHORIZATION

I authorize the Social Security Administration to furnish Sanford Health Plan with medical or other information acquired under the Title XVIII Program (MEDICARE) during the periods my contracts are in force. I authorize Sanford Health Plan, or its agent to receive medical information from physicians, hospitals, and other health care providers in order to assure appropriateness of claims payment.

I read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any Benefit Plans insured based on this application.

Signature of Applicant (Electronic Signature will not be accepted)	Date