16277

RETIREE GROUP HEALTH INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 16277 (Rev. 03-2022)

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

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

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
- ☐ 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				

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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

RETIREMENT GROUP

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

PAYMENT OPTION – MUST SELECT ONE

☐ Deduct from Pension Check (NDPERS/NDHPRS, TFFR, or Job Service only)
☐ Withhold from Bank Account (Complete SFN 50134)

NOTICE TO MEMBER

Please refer to the "Dakota Plan & Dakota Retiree Plan" information.

***If you checked YES, in order to continue or be eligible for coverage you MUST submit a photocopy of the applicable Medicare ID card(s) for both Parts A & B and complete the NDPERS Medicare Prescription Drug Plan (PDP) Individual Enrollment Form.** Therefore, any eligible Medicare member should not defer Part B of Medicare when he/she becomes eligible for it. The **NDPERS Medicare Prescription Drug Plan (PDP) Individual Enrollment Form** may be obtained on our website at www.ndpers.nd.gov or by calling NDPERS at 701-328-3900 or 1-800-803-7377.

The NDPERS Medicare Prescription Drug Plan (PDP) Individual Enrollment Form SFN 58860 cannot be signed or submitted to NDPERS more than 90 days prior to the requested effective date of coverage.

If you are drawing a pension from a NDPERS defined benefit plan (NDPERS/NDHPRS), the Teacher's Fund for Retirement (TFFR), or the Job Service Retirement Plan, your health insurance premium may be deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account by completing SFN 50134.

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 and SFN 50134 must be completed.

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.

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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