53799

# RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53799 (Rev. 06-2024)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
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## PART A MEMBER INFORMATION

| | |
|---|---|
| Name (Last, First, Middle) | NDPERS Member ID |
| Last Four Digits of Social Security Number | Date of Birth (mm/dd/yyyy) |
| Home/Personal Email Address | Home/Cell Phone Number |

## PART B NDPERS GROUP HEALTH INSURANCE

Employees terminating employment, or otherwise losing eligibility, may continue their NDPERS Group Health Coverage at their own expense for a maximum of 18 months subject to the following:

1) You must be a member of the plan at time of loss of eligibility.
2) Your spouse or any other dependent(s) applying for this continuation coverage must be a member of the plan at time of loss of eligibility.
3) You must complete and submit this election form to NDPERS within 60 days from your last date of coverage.

If you do not choose continuation coverage, your group health coverage will end on the last day of the month for which premiums were paid.

Select the level of health insurance coverage to be continued: ☐ Self Only ☐ Family* ☐ Decline/Cancel

***If electing family coverage, list all eligible covered dependents below. Attach separate sheet if more room is needed.**

*****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 to Member | Gender | Date of Birth | Social Security Number* |
|---|---|---|---|---|
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**Continue to Page 2 for Payment Method and Member Authorization.**

**PART C PAYMENT METHOD**

Your first COBRA payment is due no later than 45 days after NDPERS receives your election and must be for all months owed to date. Subsequent payments are due by the 1st of each month.

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 cancellation of COBRA continuation coverage.**

☐ 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 and on page 2. 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.

| 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 request with member signature must be submitted. The request must provide the contract holder's name, last four digits of social security number or NDPERS Member ID, and effective date. NDPERS must receive a cancellation request by the end of the month prior to the effective date. Cancellations will only be done at the end of the month. NDPERS cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

**PART D MEMBER AUTHORIZATION**

I have read this application in its entirety, including the instructions, and certify the information is accurate and complete. I understand and agree that any false statements or omissions may constitute a fraudulent act or intentional misrepresentation and may void or retroactively cancel any benefit issued based on this application.

| Signature of Member (Electronic Signature will not be accepted) | Date |
|---|---|
| | |

**Please review Page 3 for Additional Information and Instructions**

## PART A MEMBER INFORMATION

For member identification, complete all requested information.

## PART B NDPERS GROUP HEALTH INSURANCE

If continuing coverage, indicate the level of coverage. If declining or cancelling, mark "Decline/Cancel".

## PART C PAYMENT METHOD

If continuing coverage, indicate your preferred method of payment. If selecting deduct from pension check, please indicate which retirement plan you would like to withhold the premium from. If selecting withhold from bank account, please provide the bank information and/or voided check you would like to withhold the premium from. NDPERS requires that the same bank account be used for all premiums with that same payment method.

## PART D MEMBER AUTHORIZATION

You must sign and date this form for it to be valid. Electronic signatures will not be accepted.

**ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS**