53799

RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53799 (Rev. 09-2021)

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Clear Form

PART A MEMBER INFORMATION

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

PART B NDPERS GROUP HEALTH INSURANCE

Do you wish to continue your current coverage in the NDPERS Group Health Insurance Plan through COBRA Continuation?

☐ No ☐ Yes

If Yes at ☐ Current Level of Coverage; indicate level of coverage ☐ Single ☐ Family
☐ Reduced Level of Coverage (Self Only)

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.

PART C PAYMENT METHOD

NDPERS does not direct bill for premiums. If a payment method is not elected, it will be your responsibility to submit payment by the 1st of each month. Failure to remit your premium by the due date will result in loss of health coverage.

CANCELLATION POLICY

To cancel NDPERS health coverage, a written request must be submitted. The request must provide the contract holder's name, social security number 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. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

RETIREMENT GROUP	PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE	☐ Deduct from pension check ☐ Withhold from bank account (Complete SFN 50134)
☐ TIAA ☐ NDPERS DEFINED CONTRIBUTION ☐ EX-LEGISLATOR	☐ Withhold from bank account (Complete SFN 50134)

PART D MEMBER AUTHORIZATION

I have 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 Member (Electronic Signature will not be accepted)	Date

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.

PART C PAYMENT METHOD

If continuing coverage, indicate which retirement group you are receiving benefits from and your method of payment.

PART D MEMBER AUTHORIZATION

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