53504

RETIREE DENTAL/VISION INSURANCE ENROLLMENT, CHANGE, OR CANCEL

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53504 (Rev. 06-2024)

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
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Clear Form

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)			
Address	City	State	ZIP Code
Home/Cell Phone Number		Home/Personal Email Address	

ELIGIBLE RETIREMENT GROUP (select one)

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

PART B LEVEL OF COVERAGE

Both Insurance options below must be completed:

Dental Insurance: ☐ Retiree Only ☐ Retiree+Spouse ☐ Retiree+Child(ren) ☐ Retiree+Family ☐ Decline/Cancel
Vision Insurance: ☐ Retiree Only ☐ Retiree+Spouse ☐ Retiree+Child(ren) ☐ Retiree+Family ☐ Decline/Cancel

PART C EFFECTIVE DATE & REASON

Effective Date of Change (mm/dd/yyyy)

Change Reason

☐ New Coverage (Select a Reason): ☐ New Retiree ☐ Medicare Eligible ☐ Surviving Spouse
☐ Marriage (Date of Marriage _____/_____/_____)
☐ Loss of Other Coverage (Complete Part E. Must include 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 questions.
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.

Dependent Name (last, first, middle) If address is different than subscriber, indicate address under name	Relationship	Gender	Date of Birth	Social Security Number*	Court Ordered Coverage		Active Military	
					No	Yes	No	Yes
	Spouse				N/A		☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

PART E OTHER DENTAL OR VISION COVERAGE INFORMATION

If you are newly enrolled or updating your dental or vision insurance due to loss of coverage, this section must be completed. Attach a Certificate(s) of Coverage or other documentation from your insurance company showing the coverage end dates and individuals insured. **Failure to provide documentation may affect eligibility to enroll/update your insurance.**

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**

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 Eligible Dependents currently receiving or have received worker's compensation benefits? ☐ No ☐ Yes
Are you, your spouse or any 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 insurance premium(s) 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 the bank information section below.

If you are drawing a pension from TIAA or the NDPERS Defined Contribution Plan or you are an ex-legislator, your insurance premium(s) must be withheld from a bank account. Please complete the bank information section below.

NDPERS does not direct bill for premiums. **Failure to remit your premium by the due date of the 1st of the month may result in cancellation of 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. 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 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

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime. I understand my coverage begins on the effective date assigned by the carrier. If canceling coverage, I understand I will be responsible to request reimbursement from RHIC vendor for my retiree health insurance credit, if any.

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 Applicant (Electronic Signature will not be accepted)	Date Signed