



RETIREE LIFE INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53622 (Rev. 09-2021)

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)
Preferred Email Address	Telephone Number

PART B NDPERS GROUP LIFE INSURANCE

Effective Date (mm/dd/yyyy)

I elect **NOT** to Continue my Group Life Insurance

I elect **To** continue my Group Life Insurance: (Check appropriate coverages below)

Basic Life

Supplemental Life*: At Current Level of Coverage At a Reduced Level of Coverage: \$ _____ .00

Dependent Life*: At Current Level of Coverage At a Reduced Level of Coverage: \$ _____ .00

Spouse Supplemental Life*: At Current Level of Coverage At a Reduced Level of Coverage: \$ _____ .00

* Any supplemental coverage will end when the member turns 65. Carrier may offer to port or convert this coverage.

Beneficiary(ies) Update

PART C PAYMENT METHOD

RETIREMENT GROUP	PAYMENT OPTION (must select one)
<input type="checkbox"/> NDPERS/NDHPRS <input type="checkbox"/> TFFR <input type="checkbox"/> JOB SERVICE →	<input type="checkbox"/> Deduct from my Pension Check <input type="checkbox"/> Withhold from bank account (MUST Complete SFN 50134)
<input type="checkbox"/> NDPERS DEFINED CONTRIBUTION → <input type="checkbox"/> TIAA <input type="checkbox"/> EX - LEGISLATOR	<input type="checkbox"/> Withhold from bank account (MUST Complete SFN 50134)

PART D DESIGNATION OF BENEFICIARY

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. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

PRIMARY BENEFICIARY(IES)

Name	Relationship	Social Security Number*	Date of Birth	% Share must = 100%	Address

CONTINGENT BENEFICIARY(IES)

Name	Relationship	Social Security Number*	Date of Birth	% Share must = 100%	Address

PART E MEMBER AUTHORIZATION

I authorize all physicians and other medical professional, hospitals, and other medical care institution, insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators to provide ING Employee Benefits and any benefit plan administrator, consumer reporting agencies, attorneys and independent claim administrators action on ING Employee Benefits behalf with information concerning medical care, advice, treatment or supplies provide the patient including information on mental illness and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand the carrier will offer to port my term life policy(ies) or convert to a whole life policy(ies). I understand that if I elect to continue my coverage through NDPERS, I cannot port or convert the coverage with the carrier.

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 Signatures will not be accepted)	Date Signed
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PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Part A Member Information

For member identification, please provide all requested information.

Part B NDPERS Group Life Insurance

Indicate the effective date of your election.

Check the appropriate box(es) to elect the levels of coverage you had as an active employee and wish to continue. You must continue the basic life to continue the employee supplemental, the employee supplemental to continue dependent life, and the dependent life to continue spouse supplemental. Any box NOT checked will be considered an automatic cancellation of coverage.

Check the appropriate box(es) to either maintain the same level of coverage you had as an active employee or elect to decrease your level of coverage. NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Please note that any supplemental insurances will end when the member turns 65, at which time, the carrier may offer to port the term life policy(ies) or convert to a whole life policy(ies).

Part C Payment Method

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, you can have your life insurance premium deducted from your pension check. If your pension check is not large enough, you must have the premium withheld from a bank account.

If you are drawing a pension from TIAA or the NDPERS Defined Contribution Plan or you are an ex-legislator, your life insurance premiums must be withheld from a bank account.

Part D Designation of Beneficiary

Use full legal name. (Example: "Anna May Smith," not Mrs. John Smith")

A member may designate contingent beneficiary(ies) who will receive benefits if the primary beneficiary(ies) predecease member.

If you have more than two designated beneficiaries in either the primary or contingent beneficiary sections, please submit a typed attachment and include your name, NDPERS Member ID, last four digits of your social security number, date of birth, signature, and date.

If more than one person in a class (primary or contingent beneficiary) is named, they will share equally in the benefit unless specific shares are designated. If specific shares are designated, they must equal 100 percent. The benefit will be distributed as directed by the designation. If a named beneficiary does not survive, the share will be distributed among any surviving beneficiaries in proportion to the shares designated. **If shares are not designated, NDPERS will distribute benefits equally to the named beneficiary(ies).** As this distribution may not reflect the member's preference, we recommend the member be sure to designate the percent of share for each listed beneficiary.

Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established.

ESTATE DESIGNATION

If an estate is named, specify whose estate such as: "Estate of the Insured." Full name and address of the executor must be included.

TRUSTEE DESIGNATION

1. Trustee under the last will and testament of the insured, or his/her successors in trust, PROVIDED, HOWEVER, that if no claim is made by the Trustee within one year from the date of death of the insured or if the insured shall die leaving no last will and testament containing the trust covering this policy, the proceeds shall be payable to the estate of the insured. Payment of the proceeds of this policy to said Trustee or successors in trust shall fully and finally discharge the Company from all liability.
2. "The _____ Trust Company, trustee under written trust agreement date (month, date, year) _____, or its successor or successors in trust, and payment of the proceeds of this policy to said Trustee or successor or successors shall fully and finally discharge the Company from all liability." Full name and address of trust administrator must be included.

IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part E Member Authorization

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