ESTIMATED BENEFIT PAYMENT REQUEST

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 59058 (Rev. 01-2014)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328-3900 • 1-800-803-7377 • Fax 701-328-3920

PART A PARTICIPANT IDENTIFICATION

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

PART B BENEFIT ESTIMATE PARAMETERS

Retirement Effective Date:

Benefit Option:

☐Single Life ☐Normal Retirement (Judge & Highway Patrol)

☐ 50% Joint Survivor/Life ☐100% Joint Survivor/Life

☐10 Year Term Certain/Life ☐20 Year Term Certain/Life

Health Insurance: ☐Single ☐Family of 2 ☐Family of 3 or more **Medicare:** ☐No ☐Yes, # of policies_____

Life Insurance:

☐Basic Life ($1,300) ☐Supplemental Life: $_____.00 ☐Dependent Life: $_____.00

☐Spouse Supplemental Life: $_____.00

Dental: ☐Retiree Only ☐Retiree + Spouse Retiree + Child(ren) ☐Retiree + Family

Vision: ☐Retiree Only ☐Retiree + Spouse ☐Retiree + Child(ren) ☐Retiree + Family

Long Term Care Premium: $_____

Federal Income Tax:

1. ☐I elect NOT to have federal income tax withheld.

2a. ☐I want federal income tax withheld from each periodic pension payment which is figured **by using the number of allowances and marital status** shown below: (You may also designate an additional amount on line 2b.)

Step 1: Check marital status: ☐Single ☐Married ☐Married, but withholding at the higher Single rate

Step 2: Enter number of allowances → _____

2b.☐I want the following additional amount withheld. $ _____

3. ☐I want the following **flat** amount withheld $_____

North Dakota State Income Tax:

1. ☐I elect NOT to have ND State income tax withheld.

2a. ☐I want ND State income tax withheld from each periodic pension payment which is figured **by using the number of allowances and marital status** shown below: (You may also designate an additional amount on line 2b.)

Step 1: Check marital status: ☐Single ☐Married ☐Married, but withholding at the higher Single rate

Step 2: Enter number of allowances → _____

2b.☐I want the following additional amount withheld. $ _____

3. ☐I want the following **flat** amount withheld $_____

PART A PARTICIPANT INFORMATION

For member identification, please provide all requested information.

PART B BENEFIT ESTIMATE PARAMETERS

Benefit Option:
Select the option you have elected to draw your retirement benefits under.

Health Insurance:
If you elect to continue or apply for NDPERS group health insurance coverage, select level of coverage. If you or any member on the policy is or will be eligible for Medicare, please indicate the number of people.

Life Insurance:
If you elect to continue your NDPERS life insurance coverage, select the level of coverage.
If you are under age 65, you may either maintain the same level(s) of coverage you had as an active employee or elect to decrease or discontinue your level(s) of coverage. You cannot increase any coverage levels, apply for coverage you are not participating in at the time of retirement, nor are you eligible for the annual enrollment. If you are age 65 or older, you may only maintain the basic level of coverage.

Dental Insurance:
If you elect to continue or apply for NDPERS group dental insurance coverage, select level of coverage.

Vision Insurance:
If you elect to continue or apply for NDPERS group vision insurance coverage, select level of coverage.

Long Term Care Premium:
If you elect to continue or apply for NDPERS group long term care insurance, indicate the total premium you will be paying.

Federal and North Dakota State Income Tax Sections:

Your benefits from NDPERS are subject to federal and state income tax withholding. If you choose not to have tax withheld or do not have enough tax withheld, you may have to make additional tax payments to the Internal Revenue Service (IRS). You may be subject to penalties if your payments of estimated tax and withholding are not sufficient.

APPLICATION FOR DISABILITY RETIREMENT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 18000 (Rev. 01-2014)

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A PARTICIPANT IDENTIFICATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID
Daytime Telephone Number	

PART B OTHER BENEFITS

Are you eligible to receive the following benefits? Please check and complete the appropriate boxes.

YES	NO	BENEFITS	Date Benefits Began	Date Benefits Terminate	Amount	Paid Weekly	Paid Monthly
☐	☐	Workers Compensation Benefits?					
☐	☐	Unemployment Compensation Disability?					
☐	☐	Sick Pay?					
☐	☐	Social Security Benefits?					
☐	☐	Retirement Income (Current or Past Employers?)					

Has Social Security Been Applied For? ☐ Yes ☐ No

Has Worker's Compensation Benefits Been Applied For? ☐ Yes ☐ No

PART C APPLICATION FOR DISABILITY BENEFITS

SECTION 1 RETIREMENT PAYMENT OPTION (Check One)

MainSystem, Law Enforcement, or National Guard	**Highway Patrol or Judges**	**Defined Contribution Plan**
☐ Single Life ☐ 50% Joint Survivor/Life ☐ 100% Joint Survivor/Life ☐ 10 Year Term Certain/Life ☐ 20 Year Term Certain/Life	☐ Normal Retirement ☐ 100% Joint Survivor/Life ☐ 10 Year Term Certain/Life ☐ 20 Year Term Certain/Life	☐ Periodic Retirement Payment **A TIAA-CREF Distribution Form MUST be completed and accompany this application.**

SECTION 2 RETIREE HEALTH INSURANCE CREDIT OPTION (Check One)

☐ I elect the standard retiree health credit option specific to the retirement payment option selected in section 1.

☐ If married and selected the Single Life, 20 or 10 Year Term Certain, or a Defined Contribution Periodic payment; I elect the following alternate actuarially reduced retiree health credit option.

(Check One): ☐ 50% Joint Survivor Life
☐ 100% Joint Survivor Life

Name (Last, First, Middle)	NDPERS Member ID

PART D SICKNESS OR INJURY DATA

Date of Sickness or Injury	Date You First Noticed Symptoms	Date You First Saw a Physician For This Sickness or Injury

Cause of Disability

Name of Treating Physician (If more than one, list on separate sheet of paper.)

Address	City	State	Zip Code + 4

If Hospitalized For Sickness or Injury, Give Name of Hospital	Date Admitted	Date Released

Are You Bed Confined? ☐ Yes ☐ No	Are You House Confined? ☐ Yes ☐ No	Have You Ever Had The Same Kind of Sickness or Injury Before? ☐ No ☐ Yes, Specify date and physician's name and address below.

Date of Accident?	Time of Accident?	Was Accident Work Related?	Where Did The Accident Occur?

Date You Were First Able To Leave Home For Any Purpose?	Date You Were First Able To Do Any Part Of Your Work, Supervisory or Otherwise?

PART E EDUCATION

Last Year Completed	Name of School	
Last Year in School	Degree/Certificate	Additional Training
Attitude Towards School ☐Like ☐Dislike	Favorable Courses	

PART F MILITARY SERVICE

Branch	Date From: To:	Discharge ☐Honorable ☐General ☐Other (Specify)

Duties/Responsibilities

Rank	Special Training

Service Connected Disabilities

Name (Last, First, Middle)	NDPERS Member ID

PART G **WORK HISTORY** (List Most Recent First)		
Employer	Supervisor	
Job Title(s)		
Dates: From: To:	Salary	Duties
Employer	Supervisor	
Job Title(s)		
Dates: From: To:	Salary	Duties
Employer	Supervisor	
Job Title(s)		
Dates: From: To:	Salary	Duties

PART H MEMBER AUTHORIZATION

Release of Information:
To all physicians and other medical professionals, hospitals, and other medical-care, institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators:

You are authorized to provide MidDakota Clinic and any benefit plan administrators, consumer reporting agencies, attorneys, and independent claim administrators acting on MidDakota Clinic's behalf with information concerning medical care, advice, treatment, or supplies provided the patient, including information relating to mental illness and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administrating claims for benefits.

In understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. If this authorization is given in connection with a claim for disability or life insurance benefits, I understand that it is valid for the duration of the claim.

I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I elect to receive the retirement benefits and health credit as indicated in PART C. I understand I must submit a photocopy of my birth certificate. (If married, also submit a photocopy of spouse's birth certificate & marriage certificate)

I understand that this application for Disability Retirement SFN 18000 must be received by NDPERS at least 30 days before distribution of my first retirement check and within 12 months of termination of NDPERS covered employment.

Member's Signature _____ Date _____

58358

CONVERSION OF UNUSED SICK LEAVE APPLICATION– DEFINED BENEFIT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58358 (Rev. 01-2014)

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 OR (800) 803-7377 • FAX: (701) 328-3920

PART A PARTICIPANT INDENTIFICATION

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

PART B NOTICE TO MEMBER

I understand that I have the opportunity to convert any unused sick leave that I accrued with my employer as of my termination date. Payments can be made to NDPERS as an after-tax payment through a personal check or as a pre-tax payment through a direct rollover or trustee-to-trustee transfer of an eligible fund towards the retirement portion of the sick leave conversion. I have had the opportunity to speak to a financial planner and NDPERS regarding my election and to ask any questions I may have concerning this election. I understand that this election must be made prior to disbursement of any retirement benefits. My election regarding payment is indicated in Part D or Part E.

PART C HOURS OF UNUSED SICK LEAVE

Projected number of hours of unused sick leave [formula = hours ÷ 173.3 = months] (rounded up): _____
Number of months you wish to convert:_____

PART D APPLICATION FOR AFTER TAX PAYMENT THROUGH PERSONAL CHECK

☐ I elect to convert my unused sick leave and to pay for it through an after-tax payment. I understand that NDPERS will provide the cost for the sick leave conversion following my termination of employment. I will have until the 15th of the month following my month of termination to pay for the conversion. I understand that I must submit payment by the 15th of the month prior to my first retirement check date as not to delay the payment of this first benefit.

PART E APPLICATION FOR PRE-TAX PAYMENT THROUGH DIRECT ROLLOVER/TRANSFER

☐ I elect to convert my unused sick leave and to pay for the retirement portion of the conversion through a pre-tax payment by direct rollover or transfer from an eligible fund source. I understand that by electing this option, NDPERS will determine the estimated cost 60 days prior to my termination date and will provide this information to me. The direct rollover or transfer must be received by NDPERS by the 15th of the month following my month of termination. If I elect to use a direct rollover or transfer, I will submit payment for the retiree health insurance credit portion by personal check. The final cost will be calculated upon my termination. If there is a difference between the sick leave balance or conversion payment amount and the amount that I paid, then only the amount of sick leave available as of the date of termination will be added to my member record. The funds for the over-payment can not be returned due to the pre-tax nature of the funds. My member account balance will be credited with the full amount of funds received from the rollover or transfer. If an underpayment occurred, then I will pay the remaining amount by the 15th of the month following my month of termination date. I authorize my employer to document my expected salaries for the 60 days prior to my termination of employment under section F.

PART F EMPLOYER SALARY VERIFICATION – COMPLETE IF PART E ELECTED BY MEMBER

Indicate Month(s) and Projected Salary

Month	Year	Indicate Projected Gross Salary
		$
		$
		$

The salaries above are the projected gross salaries that this individual is expected to earn within 60 days of the termination date as specified on the Notice of Status or Employment Change SFN 53611. To the best of my knowledge and belief, the information that I have provided on this form is correct.

_____ _____
Signature of Authorized Agent Date

PART G MEMBER ELECTION

To the best of my knowledge and belief, the information that I have provided on this form is correct.

_____ _____
Signature of Member Date

INSTRUCTIONS

PART A PARTICIPANT IDENTIFICATION

Enter your name, NDPERS member id, last four digits of social security number, and date of birth.

PART B NOTICE OF MEMBER

Read this section carefully! This section contains important information that you need to know before making an election.

PART C HOURS OF UNUSED SICK LEAVE

Enter number of months you have eligible and number of months you wish to convert.

PART D APPLICATION FOR AFTER TAX PAYMENT THROUGH PERSONAL CHECK

Complete this section to authorize payment for your unused sick leave through a personal check.

PART E APPLICATION FOR PRE-TAX PAYMENT THROUGH DIRECT ROLLOVER/TRANSFER

Complete this section to authorize a payment for your unused sick leave through a direct rollover/transfer from an eligible fund source.

PART F MEMBER ELECTION

If Part E is elected by the member, the employer must provide written certification of the projected gross salaries to be reported to NDPERS during the final 60 days of employment.

PART G MEMBER ELECTION

The member must sign and date this section to verify their election.

DESIGNATION OF BENEFICIARY FOR THE GROUP RETIREMENT PLAN

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 2560 (Rev. 01-2014)

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.

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(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A MEMBER INFORMATION

Name (Last, First, Middle)	☐Married ☐Single ☐Divorced ☐Widowed	NDPERS ID
Date of Birth	Last Four Digits of Social Security Number	
Spouse Name (Last, First, Middle)	Spouse Gender ☐Male ☐Female	

PART B PRIMARY BENEFICIARY (IES) – Complete all sections

Name	Relationship	Social Security Number	Birth Date	% Share	Address
			Total must equal	**100%**	

PART C CONTINGENT/SECONDARY BENEFICIARY(IES)

Name	Relationship	Social Security Number	Birth Date	% Share	Address
			Total must equal	**100%**	

PART D MEMBER AUTHORIZATION

I understand that this election revokes any previous retirement account beneficiary designations. I understand that, if married, any initiation of dissolution or annulment of my marriage may void this designation. I have read and understand the terms and conditions listed on page two (2) of this designation. I hereby certify that the information provided on this form is true and correct to the best of my knowledge.

Member Signature _____ Date of Signature _____

PART E SPOUSE AUTHORIZATION

IF YOU ARE MARRIED AND DESIGNATE A BENEFICIARY OTHER THAN OR IN ADDITION TO YOUR SPOUSE, YOUR SPOUSE MUST COMPLETE THIS SECTION

If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to the listed beneficiary (ies).

If a member with three or more years of credited service is married, North Dakota law requires the spouse's consent before benefits can be paid other than to the member's spouse. (NDCC 30.1-05-02). If spouse's consent is given, please be advised, that if your primary beneficiary election is someone in addition to or in lieu of your spouse, there is no monthly pre-retirement death benefit provision.

I consent to the above retirement beneficiary (ies) designated by the above named NDPERS member.

Spouse Signature _____ Date of Signature _____

PROVISIONS FOR ALL BENEFITS

1. This "Designation of Beneficiary" is for the group Retirement Plan only. To designate beneficiary (ies) for the group Life Insurance Plan, please complete a “Life Designation of Beneficiary SFN 53855”.

2. **EFFECTIVE WHEN FILED:** This designation will be effective when properly executed and received in the NDPERS office.

3. **SUBJECT TO LAWS AND REGULATIONS:** This designation is subject to the governing statutes and to rules and regulations established by the Retirement Board of the North Dakota Public Employees Retirement System. The acceptance of the designation by NDPERS does not establish that a survivor benefit will be payable. Whether or not a benefit is payable and the amount thereof will be determined at the time of death under laws and regulations then applicable.

4. **WHO IS ELIGIBLE TO BE A BENEFICIARY:** Any person, whether or not a relative, or a church or charity may be designated as a primary or contingent beneficiary. A member may also designate his or her estate as beneficiary and the benefits will be distributed according to his or her testamentary will or according to the state laws for interstate distribution. A creditor of a member (such as a bank, credit union, loan company, etc.) may not be named a beneficiary as a means of providing security for a debt. (N.D.C.C. 28-22-19)

5. **DESIGNATED BENEFICIARIES:** All beneficiary designations shall equal 100% of the benefit. If the benefit is being divided amongst multiple beneficiaries and the total share does not equal 100%, NDPERS shall amend the designations in order to reach the 100% in total, but in no circumstance will PERS amend the beneficiary designation by more than one (1) %. If an amendment is necessary, the additional percentage shall be credited to the eldest beneficiary.

   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.

6. If there are no surviving beneficiaries, all benefits will be paid to your estate.

7. A **certified** copy of the death certificate must be sent to NDPERS to process a claim.

PROVISIONS FOR RETIREMENT BENEFITS ONLY

1. **DEATH OF ACTIVELY EMPLOYED MEMBER:**

   A. If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to whoever is the listed beneficiary(ies).
   B. If a member dies after completing three years of service, his/her retirement account will be distributed pursuant to N.D.C.C. 54-52-17(6) and N.D.C.C. 39-03.1-11(6).

2. **DEATH OF RETIREE:** Benefits will be paid to the named beneficiary based upon the option selected by the member at retirement. If there are no surviving beneficiaries, any remaining cash value will be paid to your estate.

3. **DEATH OF SURVIVING SPOUSE:** A lump sum payment of any remaining cash value will be paid to the spouse's named beneficiary. If there are no surviving beneficiaries, any remaining cash will be paid to the spouse's estate.

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

DISABILITY RETIREMENT OCCUPATIONAL DEMANDS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 54398 (Rev. 02-2014)

NDPERS ● PO Box 1657 ● Bismarck ● North Dakota 58502-1657
(701) 328- 3900 ● 1-800-803-7377 ● Fax 701-328-3920

This form should be completed in an objective manner by the employee's immediate supervisor or by another individual possessing comprehensive knowledge regarding the occupational demands of the employee's job. This form is then submitted to the treating physician for review in completing the Attending Physician's Statement. Both forms must be returned to NDPERS.

PART A PARTICIPANT IDENTIFICATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID
Job Description (Please attach a copy of the employee's job description)	

PART B PHYSICAL DEMANDS

Indicate the number of times per day for:	Lifting*	Carrying**
1-5 pounds		
6-10 pounds		
11-25 pounds		
26-50 pounds		
51-100 pounds		
100 pounds or more		

Indicate the percent of day each activity is performed:			
Sitting	%	Outside work	%
Standing	%	Working with others	%
Walking	%	Working around others	%
Inside work	%	Working alone	%

Additional Comments:

*Includes pushing and pulling effort while stationary
**Includes pushing and pulling effort while walking

What are the average hours per day worked on this job?

What are the average days per week worked on this job?

Is overtime required?
☐No ☐Yes-How many hours/day: How many days/week:

Indicate extent of performance of each of the following:

	Often	Significant	Seldom	Never
Ascending and descending stairs	☐	☐	☐	☐
Ascending and descending ladders	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐
Reaching below shoulders	☐	☐	☐	☐

Continued

Name (Last, First, Middle)	NDPERS Member ID

Occupational Requirements:

☐	Far Vision	☐	Talking
☐	Near Vision	☐	Depth Perception
☐	Hearing	☐	Other (Explain)_____

Did the employer request that the agency provide accommodations to assist employee in meeting the physical demands of the employee's job? ☐No ☐Yes, Please explain the type of accommodations provided:

PART C EMOTIONAL STRESS

Does the employee have to answer to customer complaints?
☐Often
☐Sometimes
☐Not at all

The employee is expected to perform the job at a normal, average pace…..
☐Most of the time
☐Some of the time
☐Occasionally:_____% of the time

The employee is expected to perform the job at a rapid pace….
☐Most of the time
☐Some of the time
☐Occasionally:_____% of the time

Must the employee depend upon the assistance of others in order to accomplish daily tasks? ☐No ☐Yes, how often? ☐Most of the time
☐Occasionally:_____% of the time

How close must the employee work with fellow workers?
☐Very closely
☐Significant contact
☐Minor contact

How many employees does this employee supervise? _____

Is employee routinely subject to close supervision? ☐No ☐Yes

Does the employee's job consist primarily of prescheduled activities, or of tasks that arise randomly during the day?
☐Primarily prescheduled
☐Primarily random

What percentage of the employee's time is spent meeting deadlines set by other? _____%

How much responsibility does the employee have for the overall performance of his/her particular department:
☐100 percent
☐Great deal
☐Significant
☐Minor

Continued

Name (Last, First, Middle)	NDPERS Member ID

In your opinion, what degree of emotional stress is this employee subject to during the performance of his/her job?

☐ Great
☐ Significant
☐ Some
☐ Very Little

The above questions, both involving physical demands and emotional stress, require primarily objective answers. Your subjective and/or supplementary comments would also be appreciated.

PART D CERTIFICATION

Completed by (Please Print):	
Title:	
Daytime Telephone Number:	
Address:	
Signature:	Date:

DISABILITY RETIREMENT ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 54399 (Rev. 01-2014)

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

Under the Disability Retirement Disability Plan, an employee is eligible to receive benefits if medically disabled from performing the duties of any occupation the employee may be qualified for based on individual training, education, experience, and past job history.

The patient is responsible for the completion of this form without expense to the employer.

PART A PARTICIPANT IDENTIFICATION

Name (Last, First, Mi)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth

PART B PHYSICIAN'S STATEMENT

In order to determine benefit eligibility and rehabilitation, answer the following questions:

HISTORY

Date symptoms first appeared or accident happened?	Date patient ceased work because of disability	**Has patient ever had same or similar condition?** ☐Yes ☐No
/ /	/ /	

PRESENT CONDITION

Subjective Symptoms	**Objective Findings**
Diagnosis	**Prognosis**

TREATMENT

Date of First Visit	Date of Last Visit	Frequency of Visits	Date Patient was Last Examined
/ /	/ /		/ /

EXTENT OF DISABILITY

1. Is the employee totally disabled from any occupation as defined above? ☐No ☐Yes

2. If the disability is not considered total and permanent, do you anticipate a release to their regular occupation?
☐No ☐Yes- When?

3. If you answered "no", do you anticipate a release to a less physically and/or emotionally demanding occupation?
☐No ☐Yes-When?_____
If yes, please complete the physical capacities evaluation on the back side of this form, this will provide us with the physical limitations placed on the employee.

4. If the employee is totally disabled as defined above, would you feel it appropriate to consider VOCATIONAL and/or MEDICAL REHABILITATION? ☐No ☐Yes
If yes, please complete the physical capacities evaluation on the back side of this form, this will provide us with the physical limitations placed on the employee.

MENTAL CONDITION

1. Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐No ☐Yes

Complete the appropriate section below if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.

CARDIAC

Functional Capacity (American Heart Association):	Blood Pressure
☐Class 1 (No limitation) ☐Class 3 (Marked limitation) ☐Class 2 (Slight limitation) ☐Class 4 (Complete limitation)	

VISUAL IMPAIRMENT

		O.D.	O.S.	Month	Day	Year
What was vision at last observation?	With Glasses					
	Without Glasses					

Continued

PART C PHYSICAL CAPACITIES EVALUATION

IMPORTANT: Please complete the following items based on your clinical evaluation, other testing results, patient discussions, and/or job analysis. Any item that you do not believe you can answer should be marked N/A (not available).

In an eight hour workday, claimant can: (Check time for each activity)

	1 hour	2 hours	3 hours	4 hours	5 hours	6 hours	7 hours	8 hours
Sit	☐	☐	☐	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐	☐	☐	☐

If any of the above three require alternating positions, please indicate frequency:

_____

_____

In terms of an eight hour workday, "occasionally" equals 0-33; "frequently" equals 34-36, "continuously" equals 67-100 percent.

Claimant can lift…	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

Claimant can carry…	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

Claimant can use hands for repetitive action such as:

	Simple Grasping		Pushing and Pulling		Fine Manipulation	
Right	☐Yes	☐No	☐Yes	☐No	☐Yes	☐No
Left	☐Yes	☐No	☐Yes	☐No	☐Yes	☐No

Claimant can use feet for repetitive movements as in operating foot control:

Right	☐Yes	☐No
Left	☐Yes	☐No
Both	☐Yes	☐No

Claimant is able to:	Not at all	Occasionally	Frequently	Continuously
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐

Restrictions of activities:	None	Mild	Moderate	Total
Unprotected heights	☐	☐	☐	☐
Being around marked changes in temperature and humidity	☐	☐	☐	☐
Driving automobile equipment	☐	☐	☐	☐
Exposure to dust, fumes, and gases	☐	☐	☐	☐

Remarks on Above, or other Functional Limitations:

PART D CERTIFICATION

Name (print)	Degree	Daytime Telephone Number

Mailing Address (print)	City (print)	State	Zip Code + 4

_____ _____

Signature of Attending Physician Date

18379

AUTHORIZATION FOR DIRECT DEPOSIT FOR ANNUITY PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 18379 (Rev. 01-2014)

NDPERS• 400 East Broadway, Suite 505• PO Box 1657• Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A PARTICIPANT AUTHORIZATION

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

Amount of Benefit to be Deposited: ☐ 100% ☐ _____ % ☐ $_____

Type of Account & Account Number:

☐ Checking Account Number: _____

☐ Savings Account Number: _____

I authorize the North Dakota Public Employees Retirement System (NDPERS) and the financial institution named on this form to initiate electronic fund transfer (EFT) of my retirement benefit(s) into my account as indicated below. I consent to the financial institution sharing my customer information with NDPERS for the purpose of completing the EFT arrangement.

I authorize NDPERS to initiate, a reversal or debit entry for all or any portion of any credit entry made in error by NDPERS to the designated account, including but not limited to amounts transferred after my death. If the funds remaining in the designated account are insufficient to fully reimburse NDPERS for any credit entry made in error subsequent to my death, I authorize my financial institution to release to NDPERS any information in its possession regarding the manner and party responsible for any withdrawal or transfer of funds from the designated account made subsequent to the date of the credit entry made in error.

This authorization will remain in effect until I notify NDPERS in writing to cancel it in such time as to afford NDPERS a reasonable opportunity to act on it.

I agree to the terms listed on this authorization.

_____ _____
Signature of Annuitant/Payee Date

PART B FINANCIAL INSTITUTION (Must Be Completed By Institution/Bank)

Name of Financial Institution			
Mailing Address	City	State	Zip Code
Payee's Account Number	Type of Account : ☐ Checking ☐ Savings		

Routing Number (9 Digits) ☐☐☐☐☐☐☐☐☐

We, the financial institution named on this form, agree to receive and deposit sums for the payee. We agree to notify NDPERS upon becoming aware of the death of the payee.

The payee has the right to cancel this authorization, and we reserve the right to cancel this agreement by written notice to the payee. NDPERS retains the right to reclaim all amounts paid in error to the member or authorized financial institution.

_____ _____
Signature of Financial Institution Representative Date of Signature

Financial Institution Representative (Please Print)	Title	Telephone Number

INSTRUCTIONS AND CONDITIONS

IMPORTANT NOTICE - This form is to be used only for North Dakota Public Employees Retirement System Benefit Payments.

If you wish your retirement benefit payment(s) sent to your financial organization for deposit into your savings or checking account, both you and the financial organization must complete this form to authorize this action. The North Dakota Public Employees Retirement System will forward these payments to the point you authorize. The financial organization may be any bank, savings bank, savings and loan association or similar institution, or Federal or State chartered credit union.

THIS FORM DOES NOT AUTHORIZE INSURANCE PREMIUM WITHDRAWALS FROM YOUR ACCOUNT.

PART A PARTICIPANT AUTHORIZATION

- For member identification, please provide all requested information.
- Check if you want 100% or a portion of your benefit to be direct deposited in the financial institution indicated in Part B.
- Check the type of account and print account number for the account in which this payment is to be deposited.
- Sign and date the form.

PART B FINANCIAL INSTITUTION SECTION

After completing the top portion of this form, the form should be delivered or sent to the designated financial institution. Upon completion, you and the financial institution should retain a photocopy for your records and the original is to be sent to the address at the top of this form.

CANCELLATION INSTRUCTIONS

When entered in your record with the North Dakota Public Employees Retirement System, this authorization will remain in effect until canceled by written notice by you to the North Dakota Public Employees Retirement System. The financial organization should also be notified if you cancel this agreement.

The financial organization may cancel their agreement by providing you a written notice 30 days in advance of the cancellation date. You must advise the North Dakota Public Employees Retirement System if this authorization is canceled. The financial organization cannot cancel this authorization by advice to the North Dakota Public Employees Retirement System.

FINANCIAL INSTITUTION

Immediate credit will be given the first working day of each month through your correspondent bank account at the Bank of North Dakota.

WITHHOLDING ALLOWANCE ELECTION FOR PENSION PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 51506 (Rev. 01-2014)

NDPERS • PO Box 1657 • Bismarck • ND 58502-1657
1-800- 803-7377 • 701- 328-3900 • Fax 701- 328-3920

PART A PARTICIPANT IDENTIFICATION	
Name (Last, First Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth

PART B INSTRUCTIONS

Tax Withholding is calculated for each account separately. File one form for each account you may have. Check One:

☐Main Retirement Plan ☐Defined Contribution ☐Law Enforcement ☐National Guard ☐Judge ☐Highway Patrol

☐Surviving Spouse Account ☐Job Service

Effective Date:

PART C FEDERAL WITHHOLDING ALLOWANCE

☐ 1. I elect NOT to have federal income tax withheld from each periodic pension payment (Do not complete lines 2)

☐ 2. I want federal income tax withheld from each periodic pension payment which is figured **by using the number of allowances and marital status** shown below: (You may also designate an additional dollar amount.)

Step 1: Check marital status:
☐Single ☐Married ☐Married, but withholding at the higher Single rate

Step 2: Enter number of allowances → _____

☐I want the following additional amount withheld from each periodic pension payment. (You cannot enter an amount here unless you complete line 2.) ..... $ _____

PART D NORTH DAKOTA STATE INCOME TAX WITHHOLDING

☐ 1. I elect NOT to have North Dakota State income tax withheld from each periodic pension payment (Do not complete lines 2)

☐ 2. I want North Dakota State income tax withheld from each periodic pension payment which is figured **by using the number of allowances and marital status** shown below: (You may also designate an additional dollar amount.)

Step 1: Check marital status:
☐Single ☐Married ☐Married, but withholding at the higher Single rate

Step 2: Enter number of allowances → _____

☐I want the following additional amount withheld from each periodic pension payment. ..... $ _____

PART E MEMBER AUTHORIZATION	
Member's Signature	Date of Signature

This form is available in an IRS format upon request.

Your benefits from NDPERS are subject to federal and North Dakota State income tax withholding. Use this form to inform NDPERS of your income tax withholding election. The amount withheld will automatically change as the federal tax rates are adjusted each year.

Once you make an election, it will remain in effect until you change or revoke it. You must file a new form to change your filing status and/or the number of exemptions used in determining the amount being withheld from your pension benefit.

If you choose not to have tax withheld or do not have enough tax withheld, you may have to make estimated tax payments to the Internal Revenue Service (IRS). You may be subject to penalties if your payments of estimated tax and withholding are not sufficient.

If you do not complete a Withholding Allowance Election for Pension Payments SFN 51506, NDPERS is required to withhold federal income tax as though you are married with three (3) withholding allowances. We are not required to withhold North Dakota state income tax.

Federal Income Tax Withholding

1. You can elect not to have income tax withheld by checking the box in section 1.

2. You can have federal income tax withheld based on the IRS tax table by checking and completing section 2. For federal income tax purposes, the amount of withholding is based on the marital status and the number of allowances (including zero) you identify on this form. You can also have an additional amount withheld from your NDPERS pension payment by checking and completing area provided under Step 2.

If no boxes are checked, your current federal withholding allowance and status will remain unchanged.

North Dakota Income Tax Withholding

For North Dakota residents, your NDPERS pension benefit is subject to state income taxes. If you are not a North Dakota resident, the benefits are taxable in the state in which you live.

1. You can elect not to have income tax withheld by checking the box in section 1.

2. You can have North Dakota State income tax withheld based on the IRS tax table by checking and completing section 2. For North Dakota State income tax purposes, the amount of withholding is based on the marital status and the number of allowances (including zero) you identify on this form. You can also have an additional amount withheld from your NDPERS pension payment by checking and completing area provided under Step 2.

If no boxes are checked, your current North Dakota State withholding allowance and status will remain unchanged.

Personal income tax questions should be directed to your tax advisor, accountant, or the Internal Revenue Service Center.

14120

CONTINUATION OF GROUP INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 14120 (Rev. 01-2014)

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
(701) 328-3900 • 1-800-803-7377 • Fax 701-328-3920

PART A APPLICANT INFORMATION

Name (Last, First, Middle)	Date of Birth	Last Four Digits of Social Security Number
Address	City	State / Zip + 4
Relationship to current contract holder ☐ Self ☐ Spouse/Dependant	Gender ☐ Male ☐ Female	Daytime Telephone Number
Name of current contract holder: (Last, First, Middle)		NDPERS Member ID

PART B QUALIFYING COBRA EVENT

☐ Termination of current contract holder ☐ Married
☐ Divorce from current contract holder ☐ Attained Age 26
☐ Death of current contract holder ☐ Contract holder entitled to Medicare

Date of Event:

Select the coverage(s) to be continued, check level of coverage and list covered individuals.

☐ Health Insurance: ☐ Self Only ☐ Family ☐ Waive

☐ Dental Insurance: ☐ Self Only ☐ Family ☐ Applicant & Spouse ☐ Applicant & Child(ren) ☐ Waive

☐ Vision Insurance: ☐ Self Only ☐ Family ☐ Applicant & Spouse ☐ Applicant & Child(ren) ☐ Waive

Below list all eligible covered individuals for the plan listed above. 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 Employee	Gender	Date of Birth	Social Security Number
	Self			
	Spouse			

PART C PAYMENT METHOD

PAYMENT OPTION ☐ Withhold from bank account (Complete Authorization for Automatic Premium Deduction SFN 50134)

If a payment option is not elected, you will be billed for the premium due and will have 45 days from the date of this election to make your initial premium payment. Your continuation coverage will not be effective until the initial premium payment is received. NDPERS bills the 20th of each month for the following month's coverage. Your payment is due the 1st of the month. **Failure to remit your premium by the due date will result in loss of insurance coverage.**

CANCELLATION POLICY

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

PART D APPLICANT 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 constitute a fraudulent act or intentional misrepresentation and may void or retroactively cancel any benefit issued based on this application.

_____ Signature of Applicant

_____ Date of Signature

.

PART A APPLICANT INFORMATION

For applicant identification, please provide all requested information.

PART B QUALIFYING COBRA EVENT

- Check the box that describes the event that qualifies you for continuation coverage.
- Indicate the group insurance plan(s) you are electing for continuation coverage.
- Check the level of coverage. If you are not applying for the coverage, check the waive box.
- List all covered individuals. You may elect continuation coverage for only those family members that were covered on the plan at the time of the qualifying event.

PART C PAYMENT METHOD

If you check withhold from bank account, you must complete an Authorization for Automatic Premium Deduction SFN 50134. If a payment option is not elected, you will be billed for the premium due and will have 45 days from the date of this election to make your initial premium payment. Your continuation coverage will not be effective until the initial premium payment is received. NDPERS bills the 20th of each month for the following month's coverage. Your payment is due the 1st of the month. **Failure to remit your premium by the due date will result in loss of insurance coverage.**

PART D APPLICANT AUTHORIZATION

You must sign and date this form for it to be valid.

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS

53799

RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53799 (Rev. 01-2014)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A MEMBER INFORMATION

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

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 of 2

☐ Reduced Level of Coverage (Self Only) (**SFN 16277 MUST accompany this form)**

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

DO NOT SEND MONEY WITH THIS FORM. If a payment method is not elected, you will be billed for the premium due. NDPERS bills the 20th of each month for the following month's coverage. Your payment is due the 1st of the 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-CREF ☐ 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 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. If continuing insurance, but a reduced level of coverage then a “Retiree Group Health Insurance Application SFN 16277” must accompany this application.

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.

RETIREE GROUP HEALTH INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 16277 (Rev. 01-2014)

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A MEMBER INFORMATION

Member Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Spouse Name (Last, First, Middle)	

Address	City	State	Zip Code
Daytime Telephone Number			

PART B LEVEL OF COVERAGE – CHOOSE ONE

☐ I **decline** health insurance coverage at this time
☐ Single Coverage (Self Only)
☐ Family Coverage (Self and other eligible family members)

PART C EFFECTIVE DATE & REASON

Effective Date of Change (MM-DD-YYYY):

Change Reason

☐New Coverage (Select Reason): ☐New Retiree ☐Medicare Eligible ☐Surviving Spouse
☐Marriage (Date of Marriage _____/_____/_____)
☐Loss of Other Coverage (Attach a Certificate of Creditable Coverage or Employer Verification of Insurance Coverage SFN 53621)
☐Transfer from existing policy (COBRA Ending, Non Medicare)
☐Remove Dependent/Spouse
☐ Add Dependent/Spouse: Is this an adult child? ☐No ☐Yes. Please answer the following questions.
Is adult child married? ☐No ☐Yes
Is adult child eligible to enroll under their own or spouse's employer insurance plan? ☐No ☐Yes
Is adult child Disabled? ☐No ☐Yes

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. For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
c. For Marital Status, enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed

*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.

Last Name First Name Middle Name	Relationship	Gender	Date of Birth	Marital Status	Social Security Number*
(Spouse)	Spouse				
(Dependent)					
(Dependent)					

PART E PAYMENT METHOD

RETIREMENT GROUP	PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS ☐ TFFR ☐ Job Service ☐ TIAA-CREF ☐ NDPERS Defined Contribution ☐ Ex-Legislator ☐ Alternate Retirement System	☐ Deduct from pension check (Option only available for NDPERS/NDHPRS, TFFR, Job Service) ☐ Withhold from bank account (Complete SFN 50134)

NOTICE TO MEMBER

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

If you or any eligible dependents have both Part A and Part B this form is not applicable. You must complete a "Retiree Health Insurance with Medicare Application SFN 59562" and a "Medicare Blue Rx Prescription Drug Plan Group Enrollment Form". You can obtain these forms on the NDPERS website or by calling NDPERS at 328-3900 or 1-800-803-7377.

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

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

CANCELLATION POLICY

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

PART F MEMBER AUTHORIZATION

I authorize the Social Security Administration to furnish Blue Cross Blue Shield of North Dakota with medical or other information acquired under the Title XVIII Program (MEDICARE) during the periods my contracts are in force. I authorize BCBS of North Dakota, 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 Date Signed

59562

RETIREE HEALTH INSURANCE WITH MEDICARE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 59562 (Rev. 01-2014)

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A MEMBER INFORMATION

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

Spouse Name (Last, First, Middle)

Address	City/State	Zip Code

Daytime Telephone Number

PART B LEVEL OF COVERAGE – CHOOSE ONE

☐ I **decline** health insurance coverage at this time
☐ Single Coverage (Self Only)
☐ Family Coverage (Self and other eligible family members)

PART C EFFECTIVE DATE & REASON

Effective Date of Change (MM-DD-YYYY):

☐New Coverage (Select a Reason): ☐New Retiree ☐Medicare Eligible ☐Surviving Spouse
☐Marriage (Date of Marriage _____/_____/_____)
☐Loss of Other Coverage(Attach a Certificate of Creditable Coverage or Employer Verification of Insurance Coverage SFN 53621)
☐Transfer from existing policy
☐Remove Dependent/Spouse
☐ Add Dependent/Spouse: Is this an adult child? ☐No ☐Yes. Please answer the following questions.
Is adult child married? ☐No ☐Yes
Is adult child eligible to enroll under their own or spouse's employer insurance plan? ☐No ☐Yes
Is adult child disabled? ☐No ☐Yes

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. For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
c. For Marital Status, enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed

Are you or spouse or any of your eligible dependents currently covered by Medicare due to End Stage Renal Disease? ☐No ☐Yes

Last Name First Name Middle Name	Date of Birth	Gender	Relationship	Marital Status	Medicare Part A*	Medicare Part B*	Effective Date
(Spouse)			Spouse		☐ YES ☐ NO	☐ YES ☐ NO	A: B:
(Dependent)					☐ YES ☐ NO	☐ YES ☐ NO	A: B:
(Dependent)					☐ YES ☐ NO	☐ YES ☐ NO	A: B:

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 MedicareBlue Rx Prescription Drug Plan Group Enrollment Form.** Therefore, any eligible Medicare member should not defer Part B of Medicare when he/she becomes eligible for it. The Medicare Blue Rx Prescription Drug Plan Group Enrollment Form maybe obtained on our website at www.nd.gov/ndpers or by calling NDPERS at 328-3900 or 1-800-803-7377.

The MedicareBlue RX Enrollment form 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, you can have your health insurance premium deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.

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

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written request must be submitted. The request must provide the contract holder's name, last four digits of social security number, NDPERS Member Id and effective date. A MedicareBlue Rx Disenrollment form is also required for any individual on Medicare. 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.

PART E PAYMENT METHOD

RETIREMENT GROUP			PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS	☐ TFFR	☐ Job Service	☐ Deduct from pension check (Option only available for NDPERS/NDHPRS, TFFR, Job Service)
☐ TIAA-CREF	☐ NDPERS Defined Contribution		☐ Withhold from bank account (Complete SFN 50134)
☐ Ex-Legislator	☐ Alternate Retirement System		

PART F MEMBER AUTHORIZATION

I authorize the Social Security Administration to furnish Blue Cross Blue Shield of North Dakota with medical or other information acquired under the Title XVIII Program (MEDICARE) during the periods my contracts are in force. I authorize BCBS of North Dakota, 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 Date Signed

Group
MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

Group Participant Enrollment Form

S5743_072213_GB02 RE Internal Approval 07/24/2013

Group
MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

GROUP PARTICIPANT ENROLLMENT FORM

INSTRUCTIONS: Please complete all sections of this form. Please read each statement in Section F. Sign and date where indicated in Section D. Return this enrollment form to your employer, union group administrator or other designated contact.

A. PERSONAL INFORMATION (Please Print Clearly):

Group Name:	Group Number:	**Requested Effective Date:**
Last Name: First Name:	Middle Initial:	☐Mr. ☐Mrs. ☐Ms.
Birth Date: (mm/dd/yyyy) _____	☐Male ☐Female	Home Phone Number:	Alternate Phone Number (optional):

Permanent Residence Street Address **(no P.O. Box number)**:

_____

City: State: ZIP Code:

Mailing Street Address (only if different from your Permanent Residence Street Address):

_____

City: State: ZIP Code:

B. PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please refer to your Medicare card to complete this section.

- Fill in these blanks so they match your red, white and blue Medicare card exactly.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

Name:

Medicare Claim Number: Sex:

Is Entitled To: Effective Date (mm/dd/yyyy):

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Distribution: White Copy: Carrier Yellow Copy: Enrollee

C. PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP MEDICARE COORDINATE YOUR BENEFITS:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to Group MedicareBlue Rx (PDP)?
   ☐ Yes ☐ No
   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: ID number for this coverage: Group number for this coverage:

   _____ _____ _____

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If yes, please provide the following information:
   Name of the Institution: _____
   Address and Phone Number of Institution (number and street):
   _____

If you have special needs, alternative formats are available. Please contact Group MedicareBlue Rx Customer Service at **1-877-838-3827**, 8 a.m. to 8 p.m., daily, Central and Mountain Times. TTY users should call **711**.

D. PLEASE READ SECTIONS E AND F AND SIGN BELOW:

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application, including the information in Sections E and F. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Group MedicareBlue Rx or by Medicare.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Your Signature: _____ **Today's Date:** _____

If you are the **authorized representative,** you **MUST** sign above and provide the following information:

Name (Print): _____ Phone number: _____ _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Relationship to Enrollee: _____

☐ I want all mail for this member sent to me.

E. STOP – PLEASE READ THIS IMPORTANT INFORMATION – STOP

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining Group MedicareBlue Rx, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

F. ENROLLMENT AUTHORIZATION: By completing this enrollment application, I agree to the following:

After carefully reading all statements in this section, please sign Section D of this form. Keep the copy marked "Enrollee" for your records.

1. I understand Group MedicareBlue Rx (PDP) is a Medicare-approved Part D sponsor. Coverage is available to members of an employer or union group and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota,* and Blue Cross Blue Shield of Wyoming.*
   *Independent licensees of the Blue Cross and Blue Shield Association
2. I understand Group MedicareBlue Rx is a Medicare prescription drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Group MedicareBlue Rx of any prescription drug coverage that I have or may get in the future. I can be in only one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Group MedicareBlue Rx will end that enrollment.
3. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year, or under certain special circumstances.
4. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Group MedicareBlue Rx network pharmacies.
5. I understand that once I am a member of Group MedicareBlue Rx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Group MedicareBlue Rx when I get it to know which rules I must follow to get coverage.
6. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
7. I understand that benefits, premiums and cost-sharing are subject to change during the employer group's renewal period.
8. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with one of the independent Blue Cross and Blue Shield plans offering Group MedicareBlue Rx, he/she may be paid based on my enrollment in Group MedicareBlue Rx.
9. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
10. I understand that if I obtain prescriptions outside the Group MedicareBlue Rx network, I may be required to pay any difference between the billed and allowed amount.
11. **Release of Information:** By joining this Medicare Prescription Drug Plan, I acknowledge that Group MedicareBlue Rx will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations, and as otherwise permitted by law. I also acknowledge that Group MedicareBlue Rx will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

RETIREE LIFE INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53622 (Rev. 01-2014)

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A MEMBER INFORMATION

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

PART B NDPERS GROUP LIFE INSURANCE

Effective Date:

☐ 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

☐ Beneficiary (ies) Update

PART C PAYMENT METHOD

RETIREMENT GROUP	PAYMENT OPTION (must select one)
☐NDPERS/NDHPRS ☐TFFR ☐JOB SERVICE →	☐ Deduct from my Pension Check ☐ Withhold from bank account (MUST Complete SFN 50134)
☐NDPERS DEFINED CONTRIBUTION ☐TIAA-CREF ☐EX - LEGISLATOR →	☐ 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	Birth Date	% Share must = 100%	Address

CONTINGENT BENEFICIARY(IES)

Name	Relationship	Social Security Number	Birth Date	% 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 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 Date Signed

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.

Part C Payment Method

If you are drawing a pension from a PERS 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-CREF 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 that 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.

Life Conversion Information Request Form

ReliaStar Life Insurance Company
PO Box 20, Minneapolis, Minnesota 55440
A member of the ING family of companies

Instructions

Employer/Plan Adminstrator

This form should be completed and furnished to every person who has the conversion right.

Employee/member/spouse/dependent (person requesting information)

Complete the employee/member/spouse/dependent section and mail to the insurer at the address shown below within 31 days (see your certificate for applicable time period) of the date of termination of group coverage.

To be completed by Employer/Plan Administrator

Group policyholder or plan name	Policy plan number	Account number	Group Situs
Employee's/Member's name – Last First M.I.		Date of birth	Social Security number
Is employee/member disabled? ❒ Yes ❒ No	If "Yes", give date of disability	Does policy have waiver provision? ❒ Yes ❒ No	Was ownership assigned? ❒ Yes ❒ No
Initial insurance effective date (with ReliaStar)	Employment termination date (if applicable)	Insurance termination date (DO NOT include grace period)	

Coverage terminating

❒ Employee/Member
- Basic Amount ..... $ _____
- Supplemental/Voluntary amount . $ _____
- Other ..... $ _____
- **Total amount eligible for conversion $ _____**

❒ Dependent spouse
- Basic Amount ..... $ _____
- Supplemental/Voluntary amount . $ _____
- Other ..... $ _____
- **Total amount eligible for conversion $ _____**

❒ Dependent children (each)
- Basic Amount ..... $ _____
- Supplemental/Voluntary amount . $ _____
- Other ..... $ _____
- **Total amount eligible for conversion $ _____**

Reason for termination

❒ Termination of employment
❒ Termination of group policy
❒ Reduction of coverage
❒ Retirement
❒ Loss of Dependent Status
❒ Disabled
❒ Death of Employee/Member
Spouse name_____
❒ Other (specify)_____

This form will be ❒ handed ❒ mailed to employee/member/spouse/dependent _____ (date)

Signature (employer/plan administrator)	Title	Company phone number

To be completed by employee/member/spouse/dependent (do not mail this form to insurer unless top portion is completed and signed by Employer/Plan Administrator).

Requestor's name – Last First M.I.		Relationship to employee/member	
Home address – Street	City	State	ZIP
Signature	Date	Home Phone number	

Your Group Insurance Benefits are terminating as indicated above. You may be eligible to convert to an individual life insurance policy by **mailing this form within 31 days (see your certificate for applicable time period) of such termination**.
Please read the Conversion Right in your group certificate to determine your eligibility. **Complete this form and mail without delay.** ReliaStar will send you a description of the conversion plan, premium rates and an application form.
Important Notice: This is not an application for conversion of your group life plan coverage. Receipt of this form does not guarantee your eligibility to convert your group coverage.

IF YOU DO NOT RECEIVE INFORMATION WITHIN 21 DAYS AFTER THE DATE YOU MAILED THIS FORM, PLEASE CALL (800) 955-7736.

Please mail to:
ING Employee Benefits
Group Conversions, Route 7942
PO Box 20
Minneapolis, Minnesota 55440-0020

Do not enclose payment with this form. Send the entire form, when completed, to the above address.

E-Ship: 147077 11/25/2013

PREMIUM RATES FOR WHOLE LIFE INSURANCE CONVERSION POLICIES
Rates are based on annual premium per $1,000 of insurance.

Age	Rate	Age	Rate	Age	Rate	Age	Rate
0	7.75	25	12.30	50	38.99	75	149.65
1	7.85	26	13.03	51	41.10	76	156.19
2	7.94	27	13.90	52	43.40	77	163.12
3	8.05	28	14.55	53	45.99	78	170.47
4	8.15	29	15.22	54	48.12	79	178.35
5	8.28	30	15.93	55	50.51	80	186.88
6	8.41	31	16.64	56	53.45	81	196.19
7	8.56	32	17.40	57	56.70	82	206.38
8	8.70	33	18.20	58	59.68	83	217.63
9	8.86	34	18.49	59	63.23	84	230.06
10	9.05	35	19.09	60	67.41	85	243.87
11	9.24	36	20.22	61	72.72	86	259.20
12	9.41	37	21.68	62	77.30	87	276.26
13	9.55	38	22.67	63	82.01	88	295.24
14	9.69	39	23.76	64	86.03	89	316.37
15	9.85	40	24.84	65	90.88	90	339.83
16	10.00	41	25.06	66	96.83	91	365.89
17	10.16	42	26.14	67	103.40	92	394.78
18	10.36	43	27.30	68	108.97	93	426.76
19	10.58	44	28.40	69	114.59	94	462.09
20	10.82	45	29.79	70	120.27	95	501.05
21	10.92	46	31.48	71	125.60	96	543.91
22	11.32	47	33.38	72	131.39	97	591.02
23	11.77	48	35.17	73	137.30	98	642.62
24	11.97	49	37.05	74	143.36	99	699.09

Issued by ReliaStar Life Insurance Company, policy form RL-WL2-POL-07 (may vary by state).

Example of calculating premium for Whole Life Insurance

Currently, you have $25,000 of term life insurance coverage under a policy through your employer or association. Your current age is 35. When that term life insurance stops, you want to convert the entire amount. You want to be billed semi-annually. Use the following steps to calculate the premium:

1. Determine the amount of coverage you wish to convert. **$25,000**
2. Calculate the number of thousands you wish to convert by dividing the amount from step 1 by 1,000.**25,000 divided by 1,000 = 25**
3. Find the rate corresponding to your age at the time of conversion. **$19.09**
4. Multiply the number of thousands from step 2 by the rate in step 3. **25 times 19.09 = $477.25**
5. Find a policy fee in the table below corresponding to the amount of coverage you elected in step 1. **$12.00**
6. Add the policy fee to the amount in step 4. **477.25 plus 12.00 = $489.25**
7. Multiply the amount step 6 by 0.265 for Quarterly billings, 0.515 for Semi-annual billings, and 1 for Annual billings: **489.25 times 0.515 = $251.96**

$251.96 is your semi-annual premium amount, which you need to submit with the application.

Please note: Calculate premium separately for each proposed insured person, but submit one check.

ANNUAL POLICY FEES FOR WHOLE LIFE INSURANCE	
Converted Face Amount	**Policy Fee Amount**
$1,000 – $500,000	$12.00
$500,001 - $1,000,000	$24.00
$1,000,001 - $1,500,000	$36.00
$1,500,001 - $2,000,000	$48.00

Conversion of Your Group Term Life Insurance Coverage

Protect your family.
Protect your home.
Protect your children's education.
Settle final expenses.

Why should I convert my life insurance coverage now?

As the average cost of college tuition increases and funeral expenses continue to rise, this is a good time to review your life insurance needs – for you and for those you love.

Don't let the excuse that life insurance is too expensive stop you from converting your coverage. Not having enough insurance protection could be more costly to your family, and the assets you have worked so hard to protect.

Life insurance can play a central role in a complete financial plan. Whether you are single with financial responsibilities, married with children, have kids in college, or provide care for aging parents, insurance can help protect what you value most – no matter what life stage you are in.

ING Employee Benefits is dedicated to providing the best possible benefits solutions, and can help protect your financial assets through the conversion of your group life plan coverage.

Your current term insurance coverage

Term insurance provides protection for a specific period of time and generally pays a benefit only if you die during the specified "term." Term periods are renewed annually and your rates change when entering a new age band.

LEARN MORE about converting your current term insurance coverage on the back of this page.

EMPLOYEE BENEFITS

ING

Your future. Made easier.®

Conversion can help with life's unexpected costs.

Did you know?...

Funerals and burials can be among the most expensive purchases

> The average funeral in the United States costs $7,755, according to the National Funeral Directors Association. This does not include cemetery, monument, marker costs or miscellaneous charges, such as obituary or flowers.

Information from *2010 NFDA General Price List Survey.*

College tuition continues to increase

> Published tuition and fees at private nonprofit four-year colleges and universities average **$27,293** in 2010-11; $1,164 (4.5%) higher than in 2009-10

> Average total charges, including tuition, fees, and room and board, are **$36,993**, up 4.3%

Cost and aid figures are from the *College Board's Trends in College Pricing 2010, Trends in Higher Education Series.*

Upsurge in the number of caregivers for aging parents

> More than **65 million people**, 29% of the U.S. population, provide care for a chronically ill, disabled, aged family member or friend, and spend an average of 20 hours per week providing care for them

Caregiving in the United States; National Alliance for Caregiving in collaboration with AARP; November 2009

> **36%** of family caregivers care for a parent

> **Seven out of 10** caregivers take care of loved ones who are more than 50 years old

Caregiving in the United States; National Alliance for Caregiving in collaboration with AARP. November 2009

CONVERSION OF YOUR GROUP TERM LIFE INSURANCE COVERAGE

What kind of conversion insurance plan is this?

It is referred to as an individual "non-participating" whole life insurance policy.*

Group life insurance policies contain a conversion privilege allowing insured employees, members and covered dependents to convert their group life insurance to a non-participating individual life insurance policy, without proof of good health, when coverage terminates or reduces under the group policy. Additional benefits such as the waiver of premium disability benefit, accidental death and dismemberment or accelerated benefits will not be converted.

You must apply and pay the first premium for a converted policy within a limited time period following the date any part of your group life insurance stops. A complete description of the conversion privilege is provided in your group certificate.

What are the advantages of converting group term life insurance?

Whole life insurance policies have a guaranteed cash value. They also lock in premium payments when they are issued, so you'll pay the same rate for life – no more worrying about increases in your premium.

The whole life policy being offered to you for conversion – at a fixed level premium – is payable to age 121, and includes the potential for cash value accumulations. The premium you will pay is based on the rate associated with how old you are at the time of conversion.

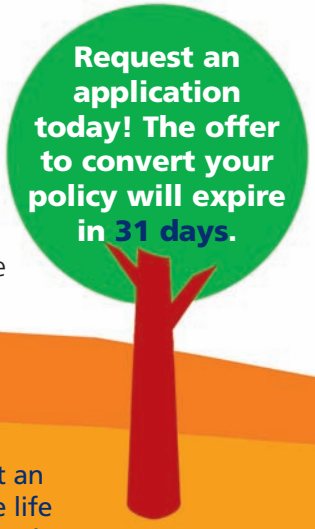
How do I convert my coverage?

Simply send in your Conversion Request Form to request an application within 31 days following the date any part of your group life insurance stops.

What is the time period for conversion?

You must return the conversion application and pay for the first premium within 21 days of the date the conversion packet was mailed to you.

You may convert any amount between $1,000 and the amount of group life insurance coverage that stops.



Return your Conversion Request Form to request an application and take advantage of a fixed whole life insurance rate for life! Please refer to your Conversion Request Form for a copy of conversion rates.

* Minnesota employees may have the option of electing Minnesota Life Continuation in place of this conversion; contact your employer for more information.

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Employee Benefits

WAIVER OF PREMIUM DISABILITY CLAIM

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)
Members of the ING family of companies
(the "Company")
ING Life Claims: PO Box 1548, Minneapolis, MN 55440, Toll-Free: 888-238-4840
ING Life Claims Overnight Address: 20 Washington Avenue So, Minneapolis, MN 55401

ING
Your future. Made easier.®

The Group, Employee, Claim Information and Certification sections must be completed by the employer. The Insured is responsible for completion of the remainder of the form. The separate Attending Physician's Statement must be completed by the Insured's attending physician. The completed forms must be sent to the above address along with copies of the Insured's enrollment forms, change forms, absolute assignments, and beneficiary changes.

CLAIM CHECKLIST

☐ Is the Employer Certification complete and signed?
☐ Has the employee completed the Insured Statement and signed the Authorization and Acknowledgment section?
☐ Has the Attending Physician's Statement been given to the employee for completion?
☐ Has the employee signed the Authorization for Release of Health Related Information?
☐ Has the Consumer Privacy Notice been given to the employee?
☐ Is the enrollment documentation and beneficiary information attached?

GROUP INFORMATION

Group Name _____

Group Number _____ Account Number _____

EMPLOYEE INFORMATION

Insured Name _____

Birth Date _____ SSN _____

Address _____ City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widow(er) Gender: ☐ Male ☐ Female

Job Title _____ Employment Start Date _____ Date Last Worked _____

Salary $ _____ per: ☐ hour ☐ week ☐ month ☐ year Last Salary Change Date _____

Employment Status: ☐ Full Time ☐ Part Time Average hours per week _____ ☐ Union ☐ Non Union

COVERAGE INFORMATION

Basic Life $ _____ Effective Date _____ Supplemental Life $ _____ Effective Date _____

Optional Life $ _____ Effective Date _____ Other $ _____ Effective Date _____

EMPLOYER CERTIFICATION

The undersigned certifies that the above statements as to the insured are correct as reported on its records.

Employer Name _____

Employer Address _____ City _____ State _____ ZIP _____

Authorized Signature _____ Date _____

Title _____ Phone (_____)_____ E-mail _____

INSURED STATEMENT *(Use separate sheet to provide additional information if needed.)*

Describe condition or illness _____

_____

Attending Physician Name *(please print)* _____ Date _____

Address _____ City _____ State _____ ZIP _____

Cause _____

Insured Name _____ SSN _____ Group Number _____

INSURED STATEMENT *(Continued)*

Other Attending Physician Name *(please print)* _____ Date _____

Address _____ City _____ State _____ ZIP _____

Cause _____

Date You Last Worked _____ Date You Became Totally Disabled _____

Are you receiving any other disability benefits? . . . . . ☐ Yes ☐ No

If "Yes," what type? _____

Are you house confined? . . . . . ☐ Yes ☐ No

Are you bed confined? . . . . . ☐ Yes ☐ No

Are you receiving any wages or salary? . . . . . ☐ Yes ☐ No

If "Yes," what type? _____

Have you returned to work? . . . . . ☐ Yes ☐ No

If "Yes," what date? _____

Do you expect to return to work? . . . . . ☐ Yes ☐ No

If "Yes," what date? _____

EDUCATIONAL BACKGROUND *(Please check the highest grade completed.)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ AA ☐ AS ☐ BA ☐ BS ☐ MA ☐ Ph.D ☐ Other _____

AUTHORIZATION AND ACKNOWLEDGMENT

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., Social Security Administration or employer to give the Company or its agents, employees and authorized representatives acting on its behalf (including ChoicePoint or any consumer reporting agency), ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information, as they apply to me. I give my permission to the Company to get consumer or investigative consumer reports about me.

I give my permission to the Company to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations -- 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between the Company and its affiliates and may be sent to MIB. This information may be made available to any Company affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with the Company or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given the Company's Consumer Privacy Notice and Insurance Information Practices Notice.

I hereby certify that the statements on this form are complete and accurate to the best of my knowledge.

➥ Insured Signature _____ Date _____

Home Phone (_____) _____ Home E-mail _____

Insured Name _____ SSN _____ Group Number _____

FRAUD WARNINGS

Alaska, Alabama, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Employee Benefits

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the ING family of companies
(the "Company")
ING Life Claims: PO Box 1548, Minneapolis, MN 55440, Toll-Free: 888-238-4840
ING Life Claims Overnight mailing address: 20 Washington Ave. So, Minneapolis, MN 55401

The completed form must be sent to the above address. The patient is responsible for the completion of this form without expense to the insurance company.

INSURED/PATIENT INFORMATION

Insured/Patient Name _____

Birth Date _____ Group Number _____

Address _____

City _____ State _____ ZIP _____

Group Information *(Give name of policyholder, i.e. employer, union or association through whom insured.)*

_____

PRESENT CONDITION

When did symptoms first appear or accident happen? _____

Date you advised patient ceased work because of disability. _____

Has patient ever had the same or similar condition? ☐ Yes ☐ No *(If "Yes," state when and describe.)* _____

_____

Subjective Symptoms _____

_____

Objective Findings *(Include results of current X-rays, EKGs or any other special tests.)* _____

_____

Patient is: ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

Diagnosis /ICD-9 Code(s) _____

_____

TREATMENT

Date of first visit _____ Date of last visit _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other _____

When did you last examine the patient? _____

PROGRESS

☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

EXTENT OF DISABILITY

Is patient totally disabled FOR ALL OCCUPATIONS? . . . . . ☐ Yes ☐ No

Is patient totally disabled FOR PATIENT'S REGULAR OCCUPATION? . . . . . ☐ Yes ☐ No

If "No," when was patient able to go to work? _____

If "Yes," is patient a suitable candidate for a rehabilitation program? . . . . . ☐ Yes ☐ No

If "Yes," when do you think patient will be able to resume work? _____

☐ Approximate date _____ ☐ Indefinite date _____ ☐ Never

Patient Name _____ Group Number _____

MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds? . . . . . ☐ Yes ☐ No

CARDIAC *(Complete this section IF disability is due to Cardiac Condition.)*

Functional Capacity (American Heart Association):
☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Blood Pressure _____

VISUAL IMPAIRMENT *(Complete this section IF disability is due to Visual Impairment.)*

What was vision at last observation? *(Snellen Notation)*

with glasses O. D. _____ O.S. _____ Date _____

without glasses O. D. _____ O.S. _____ Date _____

Date corrected vision was irrecoverably reduced to 20/200 or less in the better eye _____

☐ O.D. ☐ O.S

Vision can be restored in whole or in part by:

O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

PHYSICAL CAPACITIES EVALUATION

Patient can work full-time? . . . . . ☐ Yes ☐ No

Patient can work part-time? *(If "Yes," hours per day: _____ days per week: _____)* . . . . . ☐ Yes ☐ No

In a work day, patient can stand/walk:
(Hours at one time)
☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8-10

(TOTAL hours during day)
☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8-10

In a work day, patient can sit:
(Hours at one time)
☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8-10

(TOTAL hours during day)
☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8-10

Patient can lift/carry: ☐ Up to 10 pounds ☐ 11-20 pounds ☐ 21-50 pounds ☐ 51-100 pounds

Use of hands for repetitive action:
Manual dexterity (hold, grasp, turn): ☐ Right ☐ Left Finger dexterity (pinch, pick, use keyboard): ☐ Right ☐ Left

Dominant Hand: ☐ Right ☐ Left

Do you believe these physical capacities to be permanent?. . . . . ☐ Yes ☐ No

REMARKS

PHYSICIAN INFORMATION AND SIGNATURE

Attending Physician Name *(Please print.)* _____ Degree _____

Tax ID Number _____ Phone (_____) _____ E-mail _____

Address _____

City _____ State _____ ZIP _____

Attending Physician Signature _____ Date _____

Patient Name _____ Group Number _____

FRAUD WARNINGS

Alaska, Alabama, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor m

RETIREE VISION/DENTAL INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53504 (Rev. 01-2014)

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A MEMBER INFORMATION

Member Name (Last, First, Middle)			NDPERS Member ID
Last Four Digits of Social Security Number			Date of Birth
Spouse Name (Last, First, Middle)			
Address	City	State	Zip Code
Daytime Telephone Number			

PART B LEVEL OF COVERAGE – CHOOSE ONE

Vision		Dental	
☐ I **decline** vision insurance coverage at this time		☐ I **decline** dental insurance coverage at this time	
☐ Retiree Only	☐ Retiree + Spouse	☐ Retiree Only	☐ Retiree + Spouse
☐ Retiree + Child(ren)	☐ Retiree + Family	☐ Retiree + Child(ren)	☐ Retiree + Family

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 (Attach a Certificate of Creditable Coverage or Employer Verification of Insurance Coverage SFN 53621)
☐Transfer from existing policy (COBRA Ending, Non Medicare)
☐Remove Dependent/Spouse
☐Add Dependent/Spouse: Is this an adult child? ☐No ☐Yes. Please answer the following questions.
Is adult child married? ☐No ☐Yes
Is adult child eligible to enroll under their own or spouse's employer insurance plan? ☐No ☐Yes
Is adult child disabled? ☐No ☐Yes

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. For Relationship to you, enter one of the following: Spouse, child, stepchild, adopted child, legal guardian, or grandchild.
c. For Marital Status, enter one of the following: (S) Single, (M) Married, (D) Divorced, or (W) Widowed

*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.

Last Name	First Name	Middle Name	Relationship	Gender	Date of Birth	Marital Status	Social Security Number*
(Spouse)			Spouse				
(Dependent)							
(Dependent)							

PART E 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 health insurance premium deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.

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

CANCELLATION POLICY

To cancel NDPERS group insurance coverage, a written request must be submitted. The request must provide the contract holder's name, last four digits of social security number, 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. 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 ☐ TIAA-CREF ☐ NDPERS Defined Contribution ☐ Ex-Legislator ☐ Alternate Retirement System	☐ Deduct from pension check (Option only available for NDPERS/NDHPRS, TFFR, Job Service) ☐ Withhold from bank account (Complete SFN 50134)

PART F 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.

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 Date Signed

unum[sm]

ELECTION TO CONTINUE YOUR LONG TERM CARE INSURANCE COVERAGE

Mail to: Unum Life Insurance Company of America
LTC Customer Services
2211 Congress Street
Portland, Maine 04122

Policy Number: _____

TO BE COMPLETED BY THE EMPLOYER

Company Data: Company Name _____ Plan Number _____

Company Address: Street _____ City _____ State/Zip _____

Employee Name: Last Name _____ First Name _____ Middle Initial _____

Employee Data: Date of Birth _____ Social Security Number _____ ☐ Male ☐ Female

Person terminating group coverage: Name(s) _____ ☐ Employee ☐ Employee's Spouse or Domestic Partner (if applicable)

Reason person is terminating group coverage: ☐ Termination of Employment ☐ Death of Spouse or Domestic Partner ☐ Divorce ☐ Other

Date group coverage terminates: Month _____ Day _____ Year _____

Current monthly premium payment: Employee $_____.__/month Spouse $_____.__/month

Signature of Employer: _____ **Date:** _____

TO BE COMPLETED BY THE EMPLOYEE

If you are an insured employee, you may be eligible to continue your long term care insurance coverage after your group coverage terminates. If you wish to continue your coverage, please complete this form and return it to the insurer at the address listed above. This form must be completed and returned within the time period specified in your certificate. **You will be responsible for the entire cost of your coverage.** Unum will mail bills to you at the address you provide below.

Mailing Address: Street _____ City _____ State/Zip _____ Telephone _____

Payment Options:

Monthly	Quarterly (Paper)	Semi-Annually (Paper)	Annually (Paper)
☐ Automatic payment via checking account	☐ (3x monthly rate)	☐ (6x monthly rate)	☐ (12x monthly rate)

Signature of Employee: _____ **Date:** _____

TO BE COMPLETED BY THE EMPLOYEE'S SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

If you are the insured spouse or domestic partner or former spouse or domestic partner of the above employee, you may be eligible to continue your long term care insurance coverage after your group coverage terminates. If you wish to continue your coverage, please complete this form and return it to the insurer at the address listed above. This form must be completed and returned within the time period specified in your certificate. **You will be responsible for the entire cost of your coverage.** Unum will mail bills to you at the address you provide below.

Name: Last Name _____ First Name _____ Middle Initial _____

Mailing Address: Street _____ City _____ State/Zip _____ Telephone _____

Data: Date of Birth _____ Social Security Number _____ ☐ Male ☐ Female

Payment Options:

Monthly	Quarterly (Paper)	Semi-Annually (Paper)	Annually (Paper)
☐ Automatic payment via checking account	☐ (3x monthly rate)	☐ (6x monthly rate)	☐ (12x monthly rate)

Signature of Employee's Spouse/Domestic Partner: _____ **Date:** _____

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Information About Continuing Your Long Term Care Insurance Coverage

Should The Certificate Of Insurance Be Kept?

If you elect to continue your long term care coverage, you will not receive a new Certificate of Insurance. You should keep the Certificate of Coverage that was issued to you under the group plan.

Can Coverage Be Changed?

You may apply at any time to increase coverage by filling out a new application, which includes evidence of insurability. Call Unum at (800) 227-4165 for assistance.

Where Should Premium Payments Be Sent?

You must remit all premium payments directly to Unum. The address is:
Unum Life Insurance Company of America
P.O. Box 406933
Atlanta, Georgia 30384-6933

Your Certificate of Coverage sets forth in detail the rights and obligations of both you and the insurer. Please refer to your Certificate for more information including the number of days in your grace period, how long Unum will continue to pay for long term care benefits and when your coverage will terminate.

Unum Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122

Authorization and Agreement for Automatic Payments

Drawn By and Payable To: Unum Life Insurance Company of America
(hereinafter referred to as "the Company")

Please Print

Policy Number	Insured Name	Social Security Number

1. Check all that apply:

☐ New authorized payment request ☐ Change in bank ☐ Change in account number

2. Tape voided check in space provided below. Deposit tickets do not contain all necessary information.

Tape Voided Check Here

I (each of the undersigned) have **carefully read** the terms of this authorization, and I **understand** and **agree** that:

1) This Authorization applies to coverage provided under the policy listed above and to any coverage subsequently added.
2) My signature below reflects my intent that my account be debited by the Company in the amount necessary to pay premium.
3) No notice of premium due will be furnished while the Authorization is in effect, except, if any check or other debit entry made pursuant to this Authorization is not paid, the Company will send notice of premium past due.
4) It is my responsibility to fund my account in an amount sufficient to pay premium when due and failure to do so may result in lapse of coverage.
5) This Authorization does not waive, alter or amend any provision of coverage under the above policy.
6) No premium shall be deemed paid until the company receives payment at its Home Office.
7) The Company shall incur no liability as a result of the dishonor of any debit entry or any check, draft or other instrument drawn pursuant to this Authorization Agreement.
8) This Authorization shall remain in effect unless and until the bank, the insured person or premium payor presents written notice of termination to the Company.
   Exception: The Company may terminate this Agreement, by providing written notice thereof, in the event that, within any period of twelve consecutive months, two or more premium debits are not paid upon presentation, or if any time the Company is required to refund to the bank any amount paid pursuant to this Authorization.
9) Upon termination of this Agreement, premiums will be payable at the rate (amount) and mode (frequency) required under the Company's usual rate and mode for coverages not enrolled in the Automatic Payment Plan.
10) Funds must be paid in U.S. dollars and withdrawn from a U.S. bank.

3. Please sign. I authorize the bank indicated below to pay and charge to my account monthly debit entries, including checks, drafts and other orders by electronic or paper means, made by and payable to the Company.

Signature(s) of Premium Payor(s)	Date(s)	Bank Information
		Name
		Street
		City State Zip

4. Mail to: Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

Please retain a copy of this form for your records

PROTECTION AGAINST UNINTENTIONAL LAPSE
ADDITIONAL DESIGNATION
GROUP LONG TERM CARE INSURANCE

Your Name: _____

Your Social Security Number: _____

Policyholder's Name: _____

Policy Number: _____

You, the insured, will receive notice if any coverage for which you are required to pay the cost is about to terminate because you have not paid the required premiums.

You are required to provide your insurer with a written designation of at least one person, in addition to you, who is to receive the notice of cancellation of your coverage for nonpayment of premium OR sign a waiver electing not to designate a person. You have the right to change these designations. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to you. The designated person or persons will not receive the notice until 30 days after the premium is due and unpaid.

My designations are as follows:

Name: _____

Address: Street/P.O. Box: _____ City, State, Zip Code: _____

Name: _____

Address: Street/P.O. Box: _____ City, State, Zip Code: _____

Insured's Signature: _____ Date: _____

WAIVER ELECTING NOT TO NAME AN ADDITIONAL DESIGNATION FOR PROTECTION AGAINST UNINTENTIONAL LAPSE

I understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. **I elect NOT to designate any person to receive such notice.**

Insured's Signature: _____ Date: _____

Please return this form to:
Group Long Term Care
Unum Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122

New Jersey and New York Residents – Age 62 and older: Per New Jersey insurance code C.17:29C-1.2 and §3111 of the New York Insurance Laws, this form shall be delivered to Unum by certified mail, return receipt requested along with the completed Designee Acceptance form (on the back page of this form). Your Designee(s) must accept in writing that they are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from us.

Please retain a copy of this form for your records

DESIGNEE ACCEPTANCE
LONG TERM CARE INSURANCE

This form needs to be completed by the Designee, if the named Insured is age 62 or over and a resident of New Jersey or New York.

Insurance Applicant: Please complete this section prior to sending this form to your Designee forsignature.

Insured's Name:_____

Policy Number: _____

Prior to issuing a long term care policy; the Insured is required to provide the insurer with a written designation of at least one person, who is to receive the notice of cancellation of this policy for nonpayment of premium, in addition to the insured OR sign a waiver electing not to designate a person. You have been listed as one of the designees. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to the insured.

You must accept in writing that you are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from the insurer. Should you desire to terminate the status as a third party designee, you shall provide written notice to both the insurer and the insured.

Designee's Signature: _____

Print Name: _____

Date: _____

Please retain a copy of this form for your records

AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 50134 (Rev. 02-2014)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A PARTICIPANT IDENTIFICATION	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number:	Date of Birth

PART B MEMBER AUTHORIZATION

I authorize the following insurance premium(s) to be withheld from the Financial Institution indicated in Part B of this authorization:

☐ Health ☐ Life ☐ Dental ☐ Vision

This authorization will remain in effect until the member notifies NDPERS in writing to cancel it in such time as to afford NDPERS a reasonable opportunity to act on it. The premium amount will be deducted from the bank account by the fifth day of each month or the next working day if the fifth is on a weekend or a holiday. Your financial institution may charge an additional fee for this service.

I agree to the terms listed on this authorization.

_____ _____

Member Signature Date

PART C FINANCIAL INSTITUTION

Please attach a voided check here

IMPORTANT NOTICE - This form is to be used only for North Dakota Public Employees Retirement System Group Insurance Deductions. **THIS FORM ONLY AUTHORIZES DEDUCTIONS FROM YOUR ACCOUNT.**

INSTRUCTIONS AND CONDITIONS

If you wish to have your monthly insurance premiums deducted from your savings or checking account, you must complete this form to authorize this action. The North Dakota Public Employees Retirement System will deduct these premiums to the point you authorize. The financial institution may be any bank, savings bank, savings and loan association or similar institution, or Federal or State chartered credit union.

PART A PARTICIPANT IDENTIFICATION

For member identification, please provide all requested information.

PART B MEMBER AUTHORIZATION

Check the type of insurance premium(s) you are requesting to be withheld from your bank account. Sign and date the form.

PART C FINANCIAL INSTITUTION

Attached a voided check; if a voided check is not attached, your authorization form premium deduction will be returned.

CANCELLATION INSTRUCTIONS

When entered in your record with the North Dakota Public Employees Retirement System, this authorization will remain in effect until canceled by written notice by you to the North Dakota Public Employees Retirement System, or in the event of your death. The financial organization should also be notified if you cancel this agreement.

The financial organization may cancel their agreement by providing you a written notice 30 days in advance of the cancellation date. You must advise the North Dakota Public Employees Retirement System if this authorization is canceled. The financial organization cannot cancel this authorization by advice to the North Dakota Public Employees Retirement System.

The form is due back in our office by the 15th of the month prior to the month you want to begin your premium deduction

CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53512 (REV. 01-2014)

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
(701) 328-3900 • 1-800-803-7377 • Fax 701-328-3920

PART A PARTICIPANT/QUALIFIED BENEFICIARY INFORMATION

Name (Last, First, Middle)	PeopleSoft Employee ID (Required)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth	

PART B CONTINUATION OF COVERAGE ELECTION / WAIVER

If you elect Medical Spending Continuation coverage, it will be in effect to the end of the current plan year, or December 31.

Do you wish to continue your current participation in the NDPERS Flexcomp Plan Medical Spending Account? ☐ Yes ☐ No

☐ I wish to pre-pay the premium through the end of the plan year with pre-tax dollars deducted from my final pay checks.

☐ I will pay the premium plus a 2% administration fee with after-tax dollars through the remainder of the plan year.

PART C AUTHORIZATION OF APPLICANT

I have read the information in its entirety, **including the back page**, and agree to abide by the terms of the Plan Document. I certify, under penalties of perjury, that the information submitted on this form is true, correct and complete.

_____ _____

Applicant's Signature Date of Signature

Entitlement to COBRA Coverage

Under provisions of the Internal Revenue Service (IRS) COBRA regulations, you have the opportunity to extend your participation in the Medical Spending Account to the end of the current plan year.

The employer has the responsibility to notify NDPERS of a participant's death, termination, or reduction in hours of employment.

Qualified Beneficiaries Your spouse or dependent(s) may elect to continue coverage in a medical spending account under the following circumstances:

1. Participant's death.
2. Divorce or legal separation.
3. A dependent child ceases to be a "dependent child" under the group health plan.

If you elect COBRA continuation, your premium payment will be based on the annual election amount in existence at the time of the qualifying event.

Under the law, it is the responsibility of the person seeking continuation coverage to inform NDPERS of a divorce, legal separation or a child losing dependent status within 60 days of the date of the event. If you are interested in COBRA continuation coverage, contact NDPERS for more information.

Length of COBRA Coverage

You, your spouse or dependent(s), are eligible to receive continuation coverage until the end of the plan year, or December 31, in which the qualifying event occurred. If you have paid your premium through the end of the year on December 31 and have a balance in your account, you have the option to have eligible expenses incurred during the "grace period", from January 1 through March 15 of the new plan year, reimbursed from that remaining balance. You will have until April 30 to submit claims. Any amount remaining in your medical spending reimbursement account after the April 30 claims filing deadline is forfeited.

COBRA Coverage Premiums

Employees who elect COBRA continuation coverage are permitted to pre-tax the COBRA premium and pre-pay the premium through the end of the current plan year from their final paychecks.
To pay the premium with after-tax dollars throughout the plan year, submit the premium amount plus a two percent (2%) administrative fee by the first of each month. If you fail to pay the premium on time, your coverage will terminate on the last day of the month for which a contribution was received.

Continuation coverage under COBRA is provided subject to your eligibility. NDPERS reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

You will have 60 days from the date of this notice to inform NDPERS that you want continuation coverage.

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS OF THE DATE OF THIS NOTICE YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE