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 ☐ Divorce from current contract holder ☐ Death of current contract holder	☐ Married ☐ Attained Age 26 ☐ 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

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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