North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 • Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive
Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 • EMAIL: ndpers-info@nd.gov • www.nd.gov/ndpers/

Agenda

8:00 – 8:45 **Welcome**

8:45 – 10:15 **Health, Life, & Employee Assistance Program**

10:15 – 10:45 **Break**

10:45 – 12:00 **Vision, Dental, & Long Term Care**

FORMS

	Currently Enrolled	New Enrollment	Due Date
Health	No forms No change in coverage	Group Health Application or Waiver of Health Coverage EPO Employee Selection Form (ia) Out-of-Area Waiver Form (ia)	July 15th, 2007
Life	No forms No change in coverage	Life Insurance Enrollment/Change SFN 53803 Health Statement (EOI) for spouse supplemental over $50,000	July 15th, 2007
Dental	N/A	Dental Insurance Enrollment/Change	July 15th, 2007
Vision	N/A	Vision Insurance Enrollment/Change	July 15th, 2007
Long Term Care	N/A	Go to NDPERS Website	July 15th, 2007
Employee Assistance Programs	N/A	Automatic	July 15th, 2007
Employer Additional Forms	No forms	Appointment of Authorization SFN 17029 Employee Eligibility Report SFN 54119 Employer Based Wellness Program Commitment Agreement Employer Based Wellness Program Discount Application SFN 58436	July 15th, 2007 September 30th, 2007

BlueCross BlueShield of North Dakota

An independent licensee of the Blue Cross & Blue Shield Association

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NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

North Dakota Public Employees Retirement System (NDPERS) Group Health Application

29301733 Rev. 4-05

DCN _____

BPN _____

Please type or print in black ink. Press firmly.

GROUP ROLL _____

1. PAYROLL TO COMPLETE THIS SECTION.

Department Number	Initial	Agency Name	**Permanent Employment Date** *(mm-dd-yy)*
			– –

2. APPLICANT'S INFORMATION

Last Name	First	M.I.	Social Security Number
			– –

Mailing Address	**State in Which You Reside**	Home Phone
		( ) –
City State Zip Code	_____	Work Phone ( ) –

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed *(Give date if changing Marital Status)* – –

Sex ☐ M ☐ F

Birthdate *(mm-dd-yy)* – –

Active in the Military? ☐ Yes ☐ No

3. COVERAGE INFORMATION

☐ Basic/PPO
☐ EPO *(If applying for the EPO, you must complete the Employee Selection Form.)*
☐ Covered under spouse's NDPERS Benefit Plan Number _____

I am applying for:
☐ Single Coverage = myself only
☐ Family Coverage = myself and spouse **OR** myself and eligible children **OR** myself, spouse and eligible children

Effective Date

	01	

HEALTH (BCBSND) coverage:
☐ New Coverage (I do not have BCBSND coverage now)
☐ Transfer from NDPERS or any other coverage (If yes, complete Section 5.)
☐ COBRA/State Continuation
Change in Dependents:
☐ Add ☐ Remove Date Change Occurred – –
NOTE: You must complete Section 4 for all family members to be covered if adding or removing dependents.

4. DEPENDENT INFORMATION *(Use extra paper if necessary)*

- List all family members to be covered, other than yourself. Indicate their relationship to you, i.e. spouse, child, stepchild, etc.
- Indicate dependent's address below dependent's name **if the address is different than yours.**
- **If Marital Status is Single and you are applying for coverage for your Eligible Dependent(s), you are required to attach a copy of the state birth certificate for each dependent unless previously submitted.**

☐ Yes ☐ No **Is coverage being requested for any dependents pursuant to a court order?**

First Name	M.I.	Last *(if different)*	Relationship	Sex	Birthdate (mm-dd-yy)	Active Military	Full-Time Student	Social Security Number
			SPOUSE		– –	☐ Yes ☐ No	☐ Yes ☐ No	– –
					– –	☐ Yes ☐ No	☐ Yes ☐ No	– –
					– –	☐ Yes ☐ No	☐ Yes ☐ No	– –
					– –	☐ Yes ☐ No	☐ Yes ☐ No	– –

5. OTHER COVERAGE INFORMATION *(Attach Certificate(s) of Coverage or other documentation from your previous health insurance company. Failure to provide documentation may affect your waiting period.)*

Other Health Benefit Plan including BCBSND coverage/Publicly Sponsored Program

☐ Yes ☐ No Are you, your spouse or any of your Eligible Dependents **currently** or **previously covered** by another health benefit plan(s)? If yes, please complete this section.

Other Coverage Name and Phone Number	Policy Number	Policyholder *(first, m.i., last name)*	Birthdate *(mm-dd-yy)*
			– –

Policy Coverage Dates *(mm-dd-yy)*	Name(s) of Person(s) Covered
From – – **to** – –	

☐ Yes ☐ No Do you intend to keep your current policy in force after the effective date of this application? **If not, why?** _____

Workers' Compensation/No-Fault

☐ Yes ☐ No Are you, your spouse or any of your Eligible Dependents currently receiving or have received workers' compensation benefits?
☐ Yes ☐ No Are you, your spouse or any of your Eligible Dependents currently receiving or have received no-fault benefits?

Person's Name	Injury Date *(mm-dd-yy)*	Type of Injury	Company Providing Benefits / Phone Number
	– –		

6. SIGNATURE *(This form must be signed and dated)*

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (including the back page) and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any Benefit Plan(s) issued based on this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

X _____ – – _____

Applicant's Signature **Date Signed**

☐ Yes I am applying for coverage during **Annual Open Enrollment.**

LIMITATIONS AND EXCLUSIONS

I understand Members are subject to limitations and exclusions outlined in the relevant Benefit Plan or policy.

CONVERSION RIGHTS FOR HEALTH COVERAGE

In the event the group through which I am enrolled elects to terminate, Blue Cross Blue Shield of North Dakota has the right at its sole discretion to continue my coverage on a non-group basis subject to the premium and Benefit Plan provisions for non-group coverage then in effect.

Conversion coverage will not be offered to a Subscriber if the group through which the Subscriber is eligible has terminated coverage with Blue Cross Blue Shield of North Dakota and has enrolled as a group with another insurance carrier.

METHOD OF PAYMENT

In the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit the same to Blue Cross Blue Shield of North Dakota. This authorization is to continue in effect until revoked by me in writing.

If you require accommodation or assistance in completing this form or require this form in a different format please call the NDPERS ADA Coordinator at 701-328-3900 or 1-800-803-7377 if you are outside the Bismarck/Mandan local calling area.

For Records Management use only

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

BlueCross BlueShield
of North Dakota
An independent licensee of the Blue Cross & Blue Shield Association

Waiver of Health Coverage

PAYROLL TO COMPLETE THIS SECTION.

Department Number	Agency Name	**Permanent Employment Date** *(mm-dd-yy)*
		– –

Employee Name _____ Social Security Number ____ – ____ – ____

I have been informed that I am eligible to apply for health coverage under my employer's health Benefit Plan issued by Blue Cross Blue Shield of North Dakota. I do not wish coverage for:

☐ Myself ☐ Spouse ☐ Eligible Dependents ☐ Myself and entire family

Reason coverage is being waived:

☐ I have coverage through my spouse's employer

☐ I have other individual coverage

☐ I have Medicare coverage

☐ _____

I hereby forfeit health coverage at this time. I fully understand that if I or my Eligible Dependents desire to be covered under my employer's health Benefit Plan in the future, I and my Eligible Dependents may have a Waiting Period for Preexisting Conditions and one of the following must apply:

1. If at the time I am declining coverage, it is because:
   a. I or my Eligible Dependents have other group health coverage, and that coverage is either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours) or employer contributions toward such coverage was terminated; or
   b. coverage was under COBRA at the time I declined coverage and that coverage has been exhausted.

   Under (a.) and (b.) above, I must complete a membership application within 31 days after I lose my current coverage.
2. If I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may enroll myself and my Eligible Dependents, provided that I request enrollment within 31 days of marriage, birth, adoption or placement for adoption.
3. If I do not meet requirements under 1 or 2 above, I may apply as a Late Enrollee. Late Enrollees must request enrollment during the 31 days prior to the NDPERS Annual Enrollment Period by completing a membership application.

Employee's Signature _____ Date – – _____

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

BlueCross BlueShield
of North Dakota
An independent licensee of the Blue Cross & Blue Shield Association

Employee Selection Form

Exclusive Provider Organization (EPO)

Effective Date:_____ – ____ – _____

Employee Name: *Last* _____ *First* _____ *M.I.* _____

Employee Benefit Plan Number:_____

Employee Social Security Number:_____

❑ **NEW HIRE**	**OPEN ENROLLMENT** ❑ Transferring to EPO ❑ Changing EPO network	❑ **CANCEL EPO COVERAGE** *(will automatically convert to Basic/PPO Plan effective July 1st.)*

❑ MeritCare Medical Group — Fargo

❑ Dakota Clinic, Ltd. — Fargo

❑ Medcenter One, Inc. — Bismarck

❑ Altru Health Systems — Grand Forks

❑ Craven-Hagan/Mercy Medical — Williston

❑ PrimeCare health group — Bismarck

I understand that my Eligible Dependents and I must receive care within the provider network selected. Use of providers outside my affiliated network will result in a reduction of benefits, unless an Authorized Referral has been obtained.

Employee's Signature: _____ Date:___ – ___ – ____

If you have questions, call the NDPERS Service Unit:

Toll-Free	1-800-223-1704
Fargo Local	282-1400

Please return this form to your payroll office.

Blue Cross Blue Shield of North Dakota
NORIDIAN®
Mutual Insurance Company*

Health Benefit Plan Affiliation and Out-of-Area Waiver Form

(Please type or print in black ink)

Section 1 - Affiliation:

Please indicate the Network name and Network number you have chosen for you and your eligible dependents.

Network Name _____ Network Number _____

Section 2 - Out-of-Area Waiver:

Your or your living, covered spouse's Eligible Dependent children are eligible for this waiver if:

- They are residing at a facility for children with disabilities or other special needs (Anne Carlson School, etc.);
- They reside outside the Network Service Area and you or your living, covered spouse are required by court order to provide health coverage for them; or
- They are full-time students residing outside the Network Service Area who are financially dependent on you or your living, covered spouse.

I certify my Eligible Dependents listed below, meet at least one of the above requirements. I understand all Covered Services received by these Eligible Dependents will be reimbursed at the In-Network benefit level.

First Name:	Birthdate (mm-dd-yy)	Reside at a special needs facility	Covered by court order and residing out of area	Financially dependent full-time student residing out of area
_____	_ _ _____	☐	☐	☐
_____	_ _ _____	☐	☐	☐
_____	_ _ _____	☐	☐	☐
_____	_ _ _____	☐	☐	☐

I understand my Eligible Dependents and I must receive care within the Network I have selected, with the exception of Eligible Dependents listed in **Section 2 - Out-of-Area Waiver**. Use of providers outside my Network will result in a reduction of benefits, unless an authorized referral has been obtained or the Out-of-Area Waiver is in effect.

I authorize any Health Care Provider that has advised, treated, attended or provided care or service to me or my minor children, or is in possession of any medical information and records relating thereto, including medical information and records of DRUG AND ALCOHOL TREATMENT, MENTAL HEALTH TREATMENT AND COUNSELING AND HIV/AIDS TESTING, to furnish such medical information and records as requested to Noridian Mutual Insurance Company, d/b/a Blue Cross Blue Shield of North Dakota ("Noridian"). I further authorize Noridian to release such medical information and records to my Network Organization if I or my minor children are advised, treated, attended or provided care or service outside my Network Organization. I understand that this medical information and records will be used by my Network Organization for the management of our care.

Requested Effective Date: _____

Employer Name: _____

Employee Name: Last _____ First _____ M.I. _____

Employee Social Security #: _____

Employee Signature: _____ Date: _____

Spouse Signature (if to be insured): _____ Date: _____

White – Office Copy Canary – Representative Copy Pink – Customer Copy

LIFE INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53803 (Rev. 10-05)

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.

PART A EMPLOYER/PLAN SPONSOR

Employer/ Plan Sponsor	Control #	Account #/Location
North Dakota Public Employees Retirement System	**44374**	**1**

Date of Hire	Effective Date of Coverage	Employment Status
		☐ Active Full-Time ☐ Active Part-Time ☐ Retired

This Change is due to: (Check all that apply) — Effective Date

☐ New Hire ☐ Annual Enrollment (Must complete an EOI Form) ☐ Decrease Coverage ☐ Change of Beneficiary

☐ Birth/Adoption (Date of Change_____/_____/_____) ☐ Marital Status Change (Date of Change ____/____/_____)

PART B EMPLOYEE INFORMATION

Employee Name (Last, First, Mi)	Social Security Number	Employee I.D.#

Date of Birth	Marital Status	Gender	Work Telephone	Home Telephone
_____/_____/_____	☐ Single ☐ Married	☐ Female ☐ Male		

Employee Address	City	State	Zip Code

Department Name	Department Number

PART C EMPLOYEE COVERAGE

Basic Life

☒ Employee Only—Employer Provides $1,300 of Basic Life Coverage at no expense to you

Supplemental Life and AD&D Election: When you are first eligible for supplemental life coverage, you can elect up to the Guaranteed Issue (GI) Limit of $200,000 without providing evidence of insurability. After first eligibility, an Evidence of Insurability form (EOI) must be completed.

☐ I am applying for supplemental life coverage of: $_____. (Increments of $5,000) ☐ Waive Additional Supplemental Life & AD&D coverage

PART D DEPENDENT COVERAGE

Supplemental Dependent Life Insurance Election: When you are initially eligible for dependent coverage, you can elect it without providing evidence of insurability. After initial eligibility, an Evidence of Insurability form (EOI) must be completed for approval by The Prudential Insurance Company of America.

☐ $5,000 for eligible spouse and $5,000 for each eligible dependent child. **OR** ☐ $2,000 for eligible spouse and $2,000 for each eligible dependent child.

☐ Waive Supplemental Dependent Coverage

PART E SPOUSE COVERAGE

Supplemental Spouse/ Life Election: Only available if you elected dependent coverage of $2,000 or $5,000 in Part D. When you are initially eligible for dependent spouse/ coverage, you can elect up to $50,000 in coverage without providing evidence of insurability. Total spouse/ coverage up to $100,000 is available if your spouse/ completes an Evidence of Insurability form for approval by The Prudential Insurance Company of America. **Supplemental spouse/ coverage is limited to 50% of the employee's coverage amount.**

☐ **Amount of coverage** $_____ (Increments of $5,000) **Name** _____ **Date of Birth**_____/_____/_____

☐ Waive Supplemental Spouse Coverage

PART F BENEFICIARY INFORMATION (Designate your beneficiary(ies) below

Name of Primary Beneficiary (Last, First, Mi)	Relationship	Date of Birth	% Share (MUST =100%)	Address
Name of Contingent Beneficiary (Last, First, Mi)			% Share (MUST =100%)	Address

PART G AUTHORIZATION READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- 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 Prudential Insurance Company of America, provided I am actively at work.
- I understand that evidence or insurability may be required for coverage to become effective.

_____ Employee's Signature

_____ Date of Signature

PLEASE SIGN THIS FORM BEFORE SUBMITTING IT TO YOUR PAYROLL OFFICE

48467

Underwritten by The Prudential Insurance Company of America

GL.2005.201 Ed. 5/2005

Part A Employer/Plan Sponsor

Must be completed by an authorized agent.

Part B Employee Information

Employee must complete in its entirety.

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have 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 or elect to decrease your level of coverage.
NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part C Employee Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have 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 or elect to decrease your level of coverage.
NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part D Dependent Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have 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 or elect to decrease your level of coverage.
NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part E Spouse Coverage

Check the appropriate box to elect the level of coverage you want. You must have the basic life to have the employee supplemental, the employee supplemental to have dependent life, and the dependent life to have 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 or elect to decrease your level of coverage.
NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE

Part F Beneficiary Information

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

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 G Authorization

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

Prudential Financial

GROUP INSURANCE

The Prudential Insurance Company of America

Mail the completed form to:

The Prudential Insurance Company of America
Group Medical Underwriting, P.O. Box 8796
Philadelphia, PA 19101

Or fax the completed form to: 877-605-6671

Employer/Association Name:

Group Contract No(s):

0 0

Short Form Health Statement Questionnaire

Employee/Member First Name | MI | Last Name

Employee/Member Social Security Number

Applicant First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code

Date of Birth | Social Security Number

Sex

☐ Male ☐ Female

Height ft. in.

Weight lbs.

Please answer these questions by checking "Yes" or "No."

Yes ☐ No ☐ Do you **currently** have any disorder, condition (including pregnancy), disease, or defect or are you **currently** taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect other than a cold, cough, flu, or allergies?

Yes ☐ No ☐ **During the last five years**, have you been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment?

Yes ☐ No ☐ **During the last five years**, have you had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn?

Yes ☐ No ☐ **Within the last five years**, have you been diagnosed with, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or have you been treated for or had any trouble with any of the following: heart, chest pain, high blood pressure, cancer or tumors, diabetes, lungs, kidneys, liver?

Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.

IMPORTANT NOTICE:

In all states except Arkansas, Colorado, Florida, Maine, Maryland, Massachusetts, Ohio, Oregon, New York, New Jersey, Tennessee, Virginia, and the District of Columbia: 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.

In Arkansas, Colorado, Maine, Maryland, New York, Ohio, Tennessee, and the District of Columbia: 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.

In addition, any person who commits such a fraudulent act:

- may be subject to fines and confinement in prison under Arkansas law.
- is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages under Colorado law. Also, 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 of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- may be subject to penalties that may include imprisonment, fines, or a denial of insurance benefits under Maine law.
- may be found guilty of insurance fraud under Maryland law.
- is subject to civil penalties, with such penalties not exceeding $5,000 and the stated value of the claim for each such violation under New York law. This notice ONLY applies to disability income coverage in New York.
- is guilty of insurance fraud under Ohio law.
- is subject to penalties including imprisonment, fines, and denial of insurance benefits under Tennessee law.
- may be subject to imprisonment and/or fines under the law of the District of Columbia.

In 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.

In New Jersey: Any person who includes false or misleading information on an application for insurance under a group contract is subject to criminal and civil penalties.

In Virginia: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company has committed a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

In Massachusetts: 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 may subject such person to criminal and civil penalties.

In Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

_____ _____

Applicant's Signature (unless a minor) Date

_____ _____

If applicant is a minor, Signature of Parent, Guardian, or Person Liable for Support of Applicant Relationship Date

Dental Insurance Enrollment/Change Form

CIGNA
A Business of Caring.

INSTRUCTIONS: *Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.*

Name of Employer/Plan Sponsor:	**Group/Plan:**	**Agency/Department Name:**	**Agency/Department Number:**
North Dakota Public Employees Retirement System	**3328472**		

This change is due to:

☐Initial Eligibility Following Hire
☐Annual Enrollment
☐Late Entrant due to Change in Family Status*
☐Change Agency from _____ to _____
☐Address Change
☐Add Dependent
☐Delete Dependent
☐Cancel Coverage
☐Loss of Other Coverage
☐Termination
☐Retirement

Effective Date of Coverage or Change:

* A late entrant is an individual who is first enrolling for dental coverage after the first available opportunity.

Employee Name *(last, first, middle initial)*	☐Female ☐Male	Date of Birth / /	Social Security #
Employee Address *(street address, city, state, zip code)*	☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated	Telephone Work ( ) Home ( )	

Elect or Decline Coverage

Elect Dental Coverage	☐ **Employee Only** ☐ **Employee + Spouse** ☐ **Employee + Child(ren)** ☐ **Employee + Family**
Waive Dental Coverage	**IF YOU DO NOT WANT COVERAGE, COMPLETE THIS SECTION.** I have been given an opportunity to apply for Group Dental Insurance and have decided waive coverage for: (check all that apply) ☐myself ☐ spouse only ☐child(ren) only ☐myself and entire family

Dependent Information *Complete for covered spouse and each covered child. Attach separate sheet if more room is needed.*

Dependent Name *(last, first, middle initial)*	Relationship to Employee	Gender (F or M)	Date of Birth	Marital Status*	Child Status**	Add or Delete

* For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.
** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.

Other Dental Coverage Information *Complete if you and/if any dependent have dental coverage with another insurer or carrier.*

Employee/Dependent Name *(last, first, middle initial)*	Name and Address of Other Dental Insurer/Carrier	Policy/Plan Number	Effective Date	Other Dental Coverage Type
				☐ Single ☐ Family
				☐ Single ☐ Family

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW⬇

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- 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 CIGNA HealthCare, provided I am actively at work.

Employee's Signature	Date Signed / /

Enter your name, gender, date of birth, social security number, mailing address, marital status, and telephone numbers.

Elect Coverage

Select the level of coverage. If electing Employee + Spouse, Employee + Child(ren), or Employee + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

Waive Coverage

Select who is waiving coverage.

Other Dental Coverage

Indicate if you and/or any dependent have other dental coverage.

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

AMERITAS LIFE INSURANCE CORP.
5900 O Street, Lincoln, NE 68510
MAILING ADDRESS:
PO BOX 81889, LINCOLN, NE 68501
800-659-2223/ FAX (402)465-6133

Vision Insurance Enrollment/Change Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor **North Dakota Public Employees Retirement System**			**Group/Plan Number** **350308**
Agency/Department Name			Agency/Department Number
This change is due to: ___ Initial Eligibility Following Hire ___ Annual Enrollment ___ Late Entrant Due to Change in Family Status*	___ Cancel Coverage ___ Termination ___ Add Dependent ___ Delete Dependent	___ Change Agency From _____ to _____ ___ Loss of Other Coverage ___ Address Change ___ Retirement	**Effective Date of Coverage or Change:**

**A late entrant is an individual who is first enrolling for vision coverage after the first available opportunity.*

Employee Information

Employee Name *(last, first, middle initial)*	☐ Female ☐ Male	Date of Birth / /	Social Security #
Employee Address *(street address, city, state, zip code)*	☐ Single ☐ Married	Telephone Work ( ) Home ( )	

Elect Coverage

☐ Employee Only	☐ Employee + Child(ren)
☐ Employee + Spouse	☐ Employee + Family

Waive Coverage

IF YOU DO NOT WANT COVERAGE< COMPLETE THIS WAIVER SECTION.

I have been given the opportunity to apply for Group Vision Insurance offered by the employer, and have decided not to accept the offer for (check all that apply: ☐ myself ☐ spouse only ☐ child(ren) only ☐ myself and entire family

because: ☐ I have other coverage through my spouse's employer ☐ I have other individual coverage ☐ Other _____

Should I desire to apply for vision insurance in the future, I realize that a "late entrant" penalty may be applied.

Dependent Information Complete for covered spouse and each covered child. Attach separate sheet if more room is needed.

Dependent Name *(last, first, middle initial)*	Relationship to Employee	Gender (F or M)	Date of Birth	Marital Status*	Child Status**	Add or Delete

** For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.*
*** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.*

Other Vision Coverage Information Complete *if you and/or any dependent have vision coverage with another insurer or carrier.*

Employee/Dependent Name *(last, first, middle initial)*	Name and Address of Other Vision Insurer/Carrier	Policy/Plan Number	Effective Date	Other Vision Coverage Type
				☐ Single ☐ Family
				☐ Single ☐ Family

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium for the elected coverage
- 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 Ameritas, provided I am actively at work

Employee's Signature	Date Signed

Ameritas Life Insurance Corp.
Vision Enrollment Change Form

Enter your name, gender, date of birth, social security number, mailing address, marital status, and telephone numbers.

Elect Coverage

Select the level of coverage. If electing Employee + Spouse, Employee + Child(ren), or Employee + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

Waive Coverage

Select who is waiving coverage.

Other Vision Coverage

Indicate if you and/or any dependent have other vision coverage.

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

NOTICE OF APPOINTMENT OF AUTHORIZED AGENT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 17029 (Rev. 06/2003)

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.

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657

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

PART A PARTICIPATING AGENCY

Name of Participating Agency	Department No.
Name of Authorized Agent	Date of Appointment
Signature of Authorized Agent	Date of Signature

PART B TYPE OF APPOINTMENT

☐ Replacement of Previous Agent

Previous Agent Name: _____

☐ Addition to Present Agent

☐ New Appointment

PART C AUTHORIZED AGENT FOR

☐ Retirement	Effective Date: _____/____/_____
☐ Health	Effective Date: _____/____/_____
☐ Life	Effective Date: _____/____/_____
☐ Dental	Effective Date: _____/____/_____
☐ Vision	Effective Date: _____/____/_____
☐ Long Term Health Care	Effective Date: _____/____/_____
☐ Deferred Compensation	Effective Date: _____/____/_____
☐ FlexComp	Effective Date: _____/____/_____

PART D CERTIFICATION BY AGENCY HEAD/CONTRACTING AUTHORITY

I certify that the above named authorized agent is designated to act in this capacity for this department/agency.

_____ _____

Signature of Agency Head/Contracting Authority Date

_____

Position or Title

PART E MAILING ADDRESS

All correspondence and communications with the Authorized Agent are to be addressed as follows:

Name of Contact Person			
Address	City	State	Zip + 4 Code
E-Mail Address	Telephone Number	FAX Number	

FILING PROCEDURE: Original to NDPERS – Please retain a photocopy for your records.

PART A: PARTICIPATING AGENCY

TO BE COMPLETED BY NEW AUTHORIZED AGENT.

1. Name of participating unit and department number.

2. Name and date of appointment of new Authorized Agent.

3. Authorized Agent must sign and date.

PART B: TYPE OF APPOINTMENT

1. Check the box that identifies the type of appointment. **If this is a replacement, please be sure to list the previous Authorized Agent.**

PART C: AUTHORIZED AGENT FOR

1. Check the NDPERS program(s) the new Authorized Agent is/are to represent. **Check all boxes that apply and indicate the date when this change is effective.**

PART D: CERTIFICATION BY EXECUTIVE PERSONNEL

1. Agency head/director must sign and date this section for this form to be valid. The agency head/director should also indicate their position or title. **If the employer is controlled by a contracting authority or group, please note that a signature by a member in this contracting authority or group is required. This signature indicates that the authority or group has voted to approve this appointment.**

PART E: MAILING ADDRESS

1-4. Enter the mailing address, e-mail address, phone number, and fax number to be used by NDPERS**. If you have an email address, it is a requirement that you provide it in this section as NDPERS provides information and updates via email. If you do not have an email address, please write "N/A".**

EMPLOYEE ELIGIBILITY REPORT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 54119 (07/04)

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.

Please list the names of all employees who are on the agency's covered payroll. You must provide the requested information, the Authorized Agent for the agency is required to sign the document. This form must be returned to the NDPERS office along with the NDPERS Group Health Application and Waiver of Health Coverage for those employees who choose not to enroll in the health insurance plan. Former employee(s) currently participating on a COBRA policy, please indicate the COBRA effective date.

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

Name	Social Security Number	Date of Hire	Indicate Employment Status		COBRA Effective Date	NDPERS USE ONLY	
			Full-time	Part-time		Application	Waiver

EMPLOYER: _____ **EFFECTIVE PARTICIPATION DATE:** _____

Authorized Agent Signature (required) _____ **Date:** _____

Employer Based Wellness Program Commitment Agreement

Name of Employer: _____

Name of Agency/Employer Head: _____

As signified by my signature on the bottom of this page, I commit my support towards promoting and implementing a worksite wellness program. I understand that in order to have success, I must also promote a healthy supportive worksite culture by encouraging employees to communicate openly, be open to change, and to work together as a team. Further elements of a healthy worksite that I will strive for are encouraging employees to have fun, grow in the skills and talents that their job requires, keep work, personal and family time in balance and view risks as an opportunity to learn, even if an idea fails. Whenever possible, flexible work schedules will be available to staff.

Signature of Agency/Employer Head: _____

Wellness Coordinator Contact Information:

Name of Appointed Wellness Coordinator: _____

Telephone number: _____

Email address: _____

Mailing address: _____

Note: State agencies must participate in this program to obtain the group rate funded by the legislature this biennium.

EMPLOYER BASED WELLNESS PROGRAM DISCOUNT APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58436 (10-06)

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

Complete this application, front and back, answering every question as completely as possible, an extra sheet of paper if additional space is needed. Incomplete applications will be returned.

PART A EMPLOYER INFORMATION

Agency/Subdivision Name		Dept. #
Address	City/State	Zip
Wellness Coordinator		
E-Mail	Telephone number	
Number of active employees who are enrolled in the State of North Dakota Health Insurance Plan:		
Estimated number of individuals participating in the Wellness Program (percentage of employees participating):		

PART B MANDATORY REQUIREMENTS

Affirmative answers to the following questions are mandatory. Please affirm by initialing each box.

☐ Wellness Concurrence form signed by top management?

☐ Wellness Coordinator assigned to agency/group?

☐ Someone from the agency/group to attend or view the NDPERS Wellness Forum?

PART C MANDATORY FIVE (5) POINT SYSTEM

Five (5) points are required to qualify for the wellness discount.

☐ Communicate wellness materials provided by NDPERS/BCBS to individual employees on a monthly basis and promote the NDPERS smoking cessation program to employees. **(1 Point)**

☐ Complete a wellness activity/program (see examples provided or propose your own idea). **(2 Points)**

☐ Complete a different wellness activity/program (see examples provided or propose your own idea).**(2 Points)**

☐ Complete a comprehensive wellness program.
(Must have prior approval from NDPERS to qualify.) (**4 Points)**

TOTAL_____

EMPLOYER BASED WELLNESS PROGRAM DISCOUNT APPLICATION
SFN 58436 (10-06)

PART D WELLNESS ACTIVITY DESCRIPTION

Short-Term Wellness Activity/Program 1:

Describe the wellness activity/program you plan on offering and methods for promotion and motivation:

	YES	NO
Does your program benefit the employees in your agency/group?	☐	☐
Do you have an evaluation plan to measure the effectiveness of your program?	☐	☐
Can employees continue participation after the initial program rollout?	☐	☐
Will management be involved in the program?	☐	☐

Short-Term Wellness Activity/Program 2:

Describe the wellness activity/program you plan on offering and methods for promotion and motivation:

	YES	NO
Does your program benefit the employees in your agency/group?	☐	☐
Do you have an evaluation plan to measure the effectiveness of your program?	☐	☐
Can employees continue participation after the initial program rollout?	☐	☐
Will management be involved in the program?	☐	☐

NDPERS Approved Comprehensive Wellness Program:

Describe the wellness program you plan on offering and methods for promotion and motivation:

	YES	NO
Does your program benefit the employees in your agency/group?	☐	☐
Do you have an evaluation plan to measure the effectiveness of your program?	☐	☐
Can employees continue participation after the initial program rollout?	☐	☐
Will management be involved in the program?	☐	☐

Return the application to NDPERS.
Please retain a photocopy for your records.

USE THIS FORM IF YOU ARE TRYING TO...

NDPERS GROUP HEALTH INSURANCE FORMS:

If You Are Trying To:	Use This Form

Enrollments & Waivers

Enroll a new employee in the PPO/Basic option	New Hire Kit SFN 54360
Enroll a new employee in the EPO/Basic option	New Hire Kit SFN 54360 and Employee Selection Form
Enroll a new employee in the EPO/Basic option with covered dependents outside of EPO area	New Hire Kit SFN 54360, Employee Selection Form, and Out of Area Waiver for Dependents form
Waiver participation for new employee	Waiver of Health Coverage
Enroll a temporary/part-time employee	New Hire Kit SFN 54360
Waive participation for a new temporary/part-time employee	Waiver of Health Coverage
Switch an employee from mandatory participation to optional participation and employee is continuing participation	Notice of Status or Employment Change SFN 53611
Switch an employee from mandatory participation to optional participation and employee is electing NOT to continue to participate	Waiver of Health Coverage & Notice of Status or Employment Change SFN 53611
Switch an employee from optional participation to mandatory participation	New Hire Kit SFN 54360
Waive participation for a newly elected official	Waiver of Health Coverage

Changes/Additions

Report a name, marital, or address change	Notice of Change SFN 10766 and NDPERS Group Health Application
Report dependent loss of eligibility status	Notice of Status or Employment Change SFN 53611 and NDPERS Group Health Application
Report an employee transferring to another PERS participating agency	Notice of Transfer Kit SFN 53728
Report a leave of absence, leave of absence extension, or return from leave of absence	Notice of Status or Employment Change SFN 53611
Report an employee's classification change within agency	Notice of Status or Employment Change SFN 53611

Separation of Employment

Notify PERS of an employee's separation of employment (for all circumstances, including retirement, disability, and death)	Notice of Status or Employment Change SFN 53611

NDPERS GROUP HEALTH APPLICATION

The Group Health Application is used to enroll employees in the group health insurance plan. Employees who add or delete dependents or have a change in martial status also need to complete this form.

To assist you with enrollments, life change events, transfers, active duty/ discharge, canceling, and changing insurance coverage, refer to the **NDPERS Active Group Insurance Matrix**.

NEW ELIGIBLE EMPLOYEES (INCLUDING SEASONAL EMPLOYEES)

To be eligible, they must be:

- ✓ at least 18 years of age
- ✓ work at least 20 hours per week for 20 or more weeks per calendar year,
- ✓ and be filling positions which are regularly funded and not of limited duration (i.e. permanent).

NDPERS must accept all applications for coverage with no restrictions, limitations or waiting period for the employee and all eligible dependents. Coverage will be effective the first of the month following date of employment. If application is not made within the first 31 days of employment, the provisions of the Special Enrollment Periods will apply. An employee who elects not to enroll themselves or their eligible dependent(s) must complete a BCBS Waiver of Health Coverage form.

DEPENDENTS The Subscriber's legally married spouse, and the Subscriber's living, covered spouse's unmarried children:

Under the age of 23 are eligible if they are:

- **Financially dependent**

Children age 23 to 26 are eligible if they are:

- **A full-time student (12 credit hours) at an accredited institution and 50 % financially dependent on the employee or the employee's spouse.**

A CHILD CANNOT BE AN ELIGIBLE DEPENDENT OF MORE THAN ONE EMPLOYEE. A DEPENDENT OF AN EMPLOYEE WILL NOT BE ELIGIBLE IF THAT DEPENDENT IS ALSO AN EMPLOYEE.

PART-TIME/ TEMPORARY EMPLOYEES

A part-time/ temporary employee employed on or after August 1, 2007, is only eligible to participate if the employee is employed at least 20 hours a week and at least 20 weeks each year of employment. Coverage will be effective the

first of the month following date of employment. If application is not made within the first 31 days, the provisions of the Special Enrollment Periods will apply. NDPERS will bill the agency for the premium on the agency monthly billing. The part-time/temporary employee or the temporary employee's employer shall pay monthly the premiums in effect for the coverage being provided. The agency is responsible for collecting and remitting the monthly premium with their agency group bill. The agency is responsible for providing written verification to NDPERS that the individual is a part-time or temporary employee, the effective date of employment, the employee's name, address and social security number. The agency is also responsible for providing written verification and sending the **Continuation of Group Health Coverage for Terminating Employees SFN 14120** to NDPERS when the employee terminates. An employee who elects not to enroll themselves or their eligible dependent(s) must complete a **BCBS Waiver of Health Coverage** form.

MEMBERS OF BOARDS, COMMISSIONS, OR ASSOCIATIONS

To be eligible to participate, members of State and political subdivision boards, commissions, or associations must be paid, which means receiving a per diem for each meeting. They will have 31 days from the date they assume office in which to enroll in the group health insurance plan with coverage effective the first day of the following month. If application is not made within the first 31 days, the provisions of the Special Enrollment Periods will apply.

Eligible board members of the State may participate at their own expense. Political Subdivisions may pay a contribution, which is less than, equal to but does not exceed the premium contributions paid for eligible full-time employees.

ENROLLMENT PERIODS

The Health Insurance Portability and Accountability Act (HIPAA) is intended to ensure portability of health coverage for those individuals who must move from one plan to another as a result of loss of coverage under any other health insurance plan. The act also specifies that plans allow special enrollment opportunities for employees and prohibits using health status (medical underwriting) as a basis for group health insurance eligibility. The special enrollment periods allow an individual to enroll in the plan without any restrictions and are defined as follows:

- Within 31 days of date of hire for eligible new and seasonal employees, part-time/temporary employees, and within 31 days of assuming office for members of boards, commissions, or associations.
- Add a spouse within 31 days of marriage. An employee who previously waived coverage is eligible to enroll in the plan at the same time that the employee's spouse is enrolled.
- Add a dependent within 31 days of birth or adoption, or placement for adoption or receiving legal guardianship, or court order to provide health coverage. An employee and other dependents that previously waived coverage are also eligible to enroll in the plan at the same time that the employee's dependent is enrolled.
- Within 31 days of loss of coverage under any other health insurance plan due to death, divorce, or loss of spouse employer sponsored coverage. The employee must make application to obtain coverage within 31 days of loss of coverage. Note: the employee can only enroll themselves and dependents for coverage if the employee and/or their dependents lost coverage due to the life change event.

The following enrollment criteria will apply to individuals who enroll outside the special enrollment periods (late enrollees) previously listed:

- Late enrollees may enroll during the annual open enrollment period. Coverage will be effective January 1.
- There may be a 12-month waiting period for coverage of any pre-existing conditions. Pre-existing condition does not include maternity. **The entire waiting period will apply only if a late enrollee cannot provide confirmation of previous qualifying health insurance coverage (Certificate of Coverage) or their lapse in previous coverage exceeds 62 days.**

CONDITIONS UNDER WHICH HEALTH COVERAGE MAY BE CONTINUED

• Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act allows up to 12 weeks of unpaid leave.

Family and medical leave is available to employees who have been employed by the employer for at least 12 months and worked at least 1,250 hours for the employer during the previous 12 months.

An agency must continue health benefits at the same level and coverage had the employee not taken leave.

During a period that an employee is eligible to take family leave, the employer must continue to pay the health insurance premium for its employees under the conditions that applied immediately before the family leave began.

References:

NDCC 54-52.4 (North Dakota Family Leave Act of 1989)

Public Law 103-3 (Family and Medical Leave Act of 1993 (Federal)

If the employee does not return from medical leave, you have the right to recover any premium contributions paid while the employee was on the unpaid leave. If the employee does not return, they will have the right to COBRA continuation coverage at their own expense.

If an employee chooses not to continue the health insurance during an unpaid leave, upon their return to active, eligible employment, they will be required to complete a NDPERS Group Health Insurance Application in order to reinstate coverage. No evidence of insurability will be required. Application must be made within 31 days of return.

• Unpaid Leave of Absence

An employee may continue health insurance coverage at their own expense. If an employee elects not to continue health coverage during the leave, they will be required to complete a NDPERS Group Health Insurance Application within 31 days of return to work. Coverage will be effective the first day of the month following reinstatement of

employment.

If the employee does not return, they will have the right to COBRA continuation coverage at their own expense.

• Seasonal Employees

Seasonal employees are subject to the same requirements as stated above under "Unpaid Leave of Absence."

Payroll is required to submit a notice to NDPERS that indicates the beginning and ending dates of the leave. You must continue to collect the employee's monthly premium and submit it with the monthly billing for employees who elect to continue their coverage.

FILING PROCEDURE: ORIGINAL TO NDPERS-PLEASE MAKE PHOTOCOPIES FOR YOUR RECORDS

Employer Guide Sample

MINIMUM PARTICIPATION & MINIMUM CONTRIBUTION GUIDELINES FOR POLITICAL SUBDIVISIONS

Minimum Participation Requirements

Minimum participation requirements for the Dakota Plan are based on the size of an employer group. This is done by comparing the eligible number of full-time employees to the number of actual employees signing up for the health plan. Part-time employees or members of the Board are not considered when determining the minimum participation requirement.

Employer groups must meet the minimum participation requirements listed below:

Minimum Participation Requirements:

Total Eligible	Minimum Required	Total Eligible	Minimum Required
2	2	19	14
3	3	20	15
4	4	21	15
5	5	22	16
6	5	23	17
7	6	24	17
8	7	25	18
9	8	26	19
10	9	27	19
11	9	28	20
12	10	29	21
13	10	30	21
14	11	31	22
15	11	32	23
16	12	33	24
17	13	34	24
18	14	35	25
		36 and over	70%

For all employers, deduct from the number of eligible employees those who have Blue Cross Blue Shield in other employee groups only, or who have reputable group commercial insurance carried by their spouse or those eligible for Medicare.

If the eligible employee and/or dependent wishes to waive the coverage, a waiver **must** be submitted.

Responsibility to comply with minimum participation guidelines belongs to the employer. BCBSND will notify all employers through a letter that a participation % is needed. If the employer group does not meet the minimum requirements participation, the group will need to take steps to bring

enrollment to within guidelines. The group will have a specified amount of time to ensure adherence. If the underwriting guidelines cannot be met, the group will no longer be eligible for the Dakota Plan and must find alternative coverage within a specified time period for non-compliance of the minimum participation guidelines.

Please use the formula below to calculate whether your employer group is within minimum participation guidelines.

Total Number of Employees Eligible for Health Insurance		_____
Minus the Number of Employees Covered under Spouse Coverage, Other Employer Group Coverage or Medicare	-	_____
Equals Total Number of Eligible	=	_____
Number from the Underwriting Requirement for Your Group		_____
Number of Employees Actually Enrolled in the NDPERS Dakota Plan		_____

Review of Minimum Participation Requirements will be done on an annual basis in September.

Minimum Contribution Requirements

NDPERS requires that all *new groups* enrolled in the NDPERS health plan beginning May 1, 2004 and thereafter pay a minimum employer contribution, which is defined as a least 50% of the single premium.

Review of Minimum Contribution Requirements will be done on an annual basis in October.

An Employer Payment Plan for Health Insurance **SFN 54422** must be completed by the Authorized Agent and submitted to the NDPERS office along with the Employer Participation Agreement at the time the group enrolls in the health plan. If at any time the employer elects to change the employer health premium contribution a revised Employer Payment Plan for Health Insurance **SFN 54422** must be completed and filed with NDPERS prior to the effective date of change.

If the employer group does not meet the minimum contribution requirements, the group will need to take steps to become compliant with the guidelines. The group will have a specified amount of time to ensure adherence. If the guidelines cannot be met, the group will no longer be eligible for the Dakota Plan and must find alternative coverage within a specified time period for non-compliance of the minimum contribution guidelines.

OTHER HEALTH INSURANCE FORMS

EMPLOYEE SELECTION FORM

THIS FORM MUST BE COMPLETED AND ACCOMPANY THE NDPERS GROUP HEALTH APPLICATION IF AN EMPLOYEE INDICATES THEY ARE ELECTING EPO/BASIC COVERAGE ON THE NDPERS GROUP HEALTH APPLICATION.

PART 1: SELECTION OF PROVIDER

The applicant must select "ONE" provider. ***The EPO provider must be within a 50-mile radius of the member's residence.***

PART 2: EMPLOYEE AUTHORIZATION

The applicant must complete the requested information and sign and date the form.

FILING PROCEDURE: ORIGINAL TO NDPERS-PLEASE MAKE PHOTOCOPIES FOR YOUR RECORDS

WAIVER OF HEALTH COVERAGE

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) (FEDERAL LAW): REQUIRES THIS FORM MUST BE COMPLETED AT THE TIME OF INITIAL ELIGIBILITY BY ALL ELIGIBLE EMPLOYEES (INCLUDES PERMANENT AND PART-TIME, TEMPORARY OR SEASONAL) IF THEY ELECT NOT TO ENROLL THEMSELVES OR THEIR ELIGIBLE DEPENDENT(S) IN THE GROUP HEALTH INSURANCE PLAN.

The employee must complete all requested information and sign and date the form.

FILING PROCEDURE: ORIGINAL TO NDPERS-PLEASE MAKE PHOTOCOPIES FOR YOUR RECORDS

NOTICE OF CHANGE
SFN 10766

This form is to be completed to notify NDPERS of:

- Name change
- Address change
- Marital Status change

Whenever the Notice of Change SFN 10766 is completed and sent to NDPERS, the authorized agent must certify the accuracy of the information or the member and the form must be dated. If someone other than the authorized agent or member signs the form, it will be returned for the proper signature.

1. Complete a martial status change whether there is a name change or not.
2. Name changes should match the name the member has filed with Social Security.
3. The authorized agent or the member must sign Part E for this form to be valid.

FILING PROCEDURE: Original to NDPERS – Please retain a photocopy for your records.

NOTICE OF TRANSFER
SFN 53728

All instructions, terms and conditions are in the NDPERS Notice of Transfer Kit SFN 53728.

IF THE EMPLOYEE WILL NOT BEGIN EMPLOYMENT WITH A NEW PARTICIPATING AGENCY WITHIN 31 DAYS FROM THE DATE OF EMPLOYEE'S LAST REGULAR PAYCHECK WITH YOUR AGENCY, BOTH THE EMPLOYEE AND THE AUTHORIZED AGENT MUST COMPLETE A SEPARATION OF EMPLOYMENT KIT.

ADMINISTRATIVE CODE CHAPTER 71-02-01-01(24): "TERMINATION OF EMPLOYMENT" MEANS A SEVERANCE OF EMPLOYMENT BY NOT BEING ON THE PAYROLL OF A COVERED EMPLOYER FOR A MINIMUM OF ONE MONTH. APPROVED LEAVE OF ABSENCE DOES NOT CONSTITUTE TERMINATION OF EMPLOYMENT.

Often employees will terminate their position with an employer participating in NDPERS and take a job with another employer who is also participating in NDPERS (NDPERS Participating Employer Groups).

1. Employees can not change their level of health insurance coverage. However, they may change EPO networks if the transfer results in the employee moving into or out of an EPO network area.

If employee transfers employment from one participating employer to another participating employer without terminating eligible employment, and in recognition of the fact that the current employer may not be aware of the circumstances regarding a departing employee's employment plans and subsequently a new employer will not receive any transfer information, NDPERS has developed a series of scenarios along with the required administrative procedures to follow depending on the particular situation. These procedures are designed to ensure transfers are processed consistently based on "what the employer knows at the time of separation of employment.

Situation: **Current employer knows the employee is transferring to another covered employer:**

1. Complete the Notice of Transfer Kit **SFN 53728**, which contains the Notice of Transfer form.
2. Send Notice of Transfer form to the new employer

Situation: **Current employer has no knowledge that terminating employee is transferring to another covered employer:**

1. Current employer and employee complete the appropriate separation of employment kit
2. Send the complete kit to PERS
3. PERS will process accordingly in absence of any other information.

Situation: **New employer receives a Notice of Transfer Form from a participating employer.**

1. Do not have transferring employee complete new enrollment forms for plans indicated in Part C of Notice of Transfer Form
2. Set up employee with benefits according to information provided in Part C of Notice of Transfer Form
3. Have employee complete enrollment forms for programs not previously enrolled in through previous employer
4. Submit any new enrollment forms to PERS

Situation: **New employer is not aware a new employee is a transfer from another participating employer. Previous employer processed as a separation of employment and employee does not provide the information.**

1. Have new employee complete all required enrollment forms.
2. Send the enrollment forms to PERS.
3. If there is an existing record, and the hire date is within 31 days of separation from previous employer, PERS will notify you that employee is a transfer from another participating employer and will:
   a. Void the enrollment forms for any programs that employee previously participated in.
   b. Complete Parts A-D of the Notice of Transfer Form and send it to new employer.
   c. Employer will set up benefit record according to information provided in Part C of the Notice of Transfer Form
   d. Employer must complete Parts E and F on the Notice of Transfer Form and return it to PERS

Situation: **New employer is aware a new employee is a transfer but previous employer treated as a separation of employment and did not complete a Notice of Transfer Kit SFN 53728.**

1. Complete Parts A, E, and F of the Notice of Transfer Form.
2. Send Notice of Transfer Form to PERS.

3. If hire date is within 31 days of separation from previous employer, PERS will complete Part C based on existing record and return the form to the new employer.

4. Have employee complete enrollment forms for programs not previously enrolled in through previous employer.

5. Employer will set up the benefit record accordingly.

FILING PROCEDURE: Original to NDPERS – Please retain a photocopy for your records.

Employer Guide Sample

NOTICE OF STATUS OR EMPLOYMENT CHANGE
SFN 53611

This form is to be completed by the employer when the employee has a change in employment Status. (Instructions and conditions are also listed on the other side of this form).

This form is to be completed to notify NDPERS of:

- Employee leave of absence/ leave without pay
- Extending leave of absence/ leave without pay
- Employee's return from leave of absence
- Employee classification change within agency
- Employee's reduction in hours
- Employee's separation from employment

PART B: CHANGE OF STATUS

LEAVE OF ABSENCE

1. NDPERS must be notified whenever an employee is taking a leave without pay and the reason for the leave.
2. A leave of absence cannot exceed one year without being recertified. If an employee is taking an unpaid leave in excess of two years, the employee should be terminated.
3. NDPERS must be notified of a return from leave prior to the employer enrolling the employee in the dental plan. If an employee elects not to continue dental coverage during the leave, they may be required to complete the Re-enrollment Restriction Period set forth in the Schedule of Benefits.

CLASSIFICATION CHANGE

1. Often employees will change their position within the employer group. This may affect their eligibility for benefits, as well as, how the employee is reported to NDPERS.

REDUCTION IN HOURS

1. If notifying PERS of an employee's change from permanent to temporary service, this form must be accompanied by **SFN 17627**.

PART C: SEPARATION OF EMPLOYMENT

1. If an employee is leaving the employer's service due to Termination (pre-retirement), Retirement, Disability retirement, or Death, this form is in one (1) of 6 PERS separation of employment kits. The **EMPLOYER MUST COMPLETE** a Notice of Status or Employment Change **SFN 53611.** The PERS separation of employment kit includes all necessary forms the employer and employee are required to complete.

   The employer or employee may obtain the following Kits:

   - Refund/Rollover Kit **SFN 53725**
   - Deferred Retirement Kit **SFN 53724**
   - Disability Retirement Kit **SFN 53726**
   - Retirement Kit **SFN 53723**

2. The "membership termination date" is the last date the employee worked at your agency in an eligible position.

3. The "last month insurance premium(s) will be paid by your agency/or this employee". This is the last month the employee will be on your group insurance billing.

NDPERS would like to remind employer's that participate in the group health plan of the Administrative Rules pertaining to final payment of the health insurance premium for terminating employees. Administrative Code section 71-03-04-01 pertaining to state agencies and section 71-03-07-01 pertaining to political subdivisions clarify that an employee's coverage must end the month following the month after termination of employment. This means the employer must remit premium payment for insurance coverage for the month following the month of termination in order to comply with this requirement. In addition, when an employee transfers from one participating employer to another, the new employer is responsible for submitting the premium for the first of the month following the month of employment."

PART D: PLAN INFORMATION

1. The employer must always complete this section.

PART E: AUTHORIZATION OF AUTHORIZED AGENT

1. The employer's authorized agent must always sign this section for the form to be valid.

FILING PROCEDURE: Original to NDPERS – Please retain a photocopy for your records.

CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)

Employee - SFN 14120 Dependent – SFN 53883

FEDERAL COBRA LAW

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers provide employees and their dependents that lose their eligibility to participate in the Group Health Plan an opportunity to continue comparable coverage at their own expense.

1. **PERSONS AFFECTED:** The right to COBRA continuation coverage applies to all employees and must be offered to:
   - A. Employees who terminate either voluntarily or involuntarily. Termination as a result of gross misconduct is not accepted;
   - B. An employee's divorced or widowed spouse;
   - C. Spouses and dependent(s) losing coverage due to a terminated employee's eligibility for Medicare;
   - D. Dependents who lose eligibility.

Employees no longer eligible for participation in the Group Health Plan may be eligible for COBRA coverage for a period of up to 18 months. Dependents (including spouses) no longer eligible for participation in the Group Health Plan may be eligible for COBRA coverage for a period of up to 36 months.

2. **COVERAGE WILL NOT BE PROVIDED IF:**
   - A. The individual enrolls in another Group Health Plan or they (or any dependent) become eligible for Medicare while on COBRA continuation.
   - B. The premium is not paid in a timely manner;
   - C. The employer ceases to provide the Group Health Plan to any employees;
   - D. The (ex) spouse enrolls in another Group Health Plan (including a new spouse's Group Health Plan if they re-marry);
   - E. The dependent enrolls in another Group Health Plan (excluding CHAMPUS).

FILING PROCEDURE: ORIGINAL TO NDPERS-PLEASE MAKE PHOTOCOPIES FOR YOUR RECORDS

GROUP HEALTH AND LIFE INSURANCE
MONTHLY RECONCILING PROCEDURES

Pay Direct Agencies - **All agencies that are not on Central Payroll.**
(Counties, Cities, School Districts, District Health Units, Higher Ed, etc.)

The monthly Group Insurance Billings are sent out on or about the 1st of each month.

Step 1. Verify Coverage. Review the billing to make sure it includes the employees who should have insurance coverage for the billing month. **Do not cross out names on the billing.** To report additions, deletions, or changes that reflect the current month's coverage, use the Adjustments page of the billing. If applications reflecting these changes have not been sent to NDPERS, they must be sent along with the billing for processing. Make changes to level of coverage on the adjustment page as follows:

Additions - Enter Last Name, First Name, Social Security Number and add insurance premium amounts to the amount billed.

Deletions - Enter Last Name, First Name, Social Security Number and subtract insurance premium amounts from the amount billed.

Changes in level of coverage – Record the old level of coverage as a deletion and the new level of coverage as an addition.

The entries on the adjustment page should only be for changes to an employee's insurance coverage for the current month (additions, cancellations, etc).

Step 2. Reconcile payment to billing. The amount of premium that should be remitted with the billing should equal the original amount billed, plus any additions, less any deletions. If the payment does not equal the adjusted billing, you must provide a reconciliation of your payment amount to the billing as follows. Be sure to include the employee's name, premium amount and month for each adjustment.

Premium payment
Add premiums that you owe for the current month, that are not included in your payment
Subtract premiums that you paid for the current month, that you are requesting a refund for
Subtract premiums that are included in your payment that are for a prior month
Total must equal adjusted billing

This same process applies to employers who are remitting premium payments through ACH.

Step 3. Return the original billing, along with your premium check and premium reconciliation to NDPERS by the 10th of each month.

The remittance enclosed with your insurance billing should be for insurance premiums only. Do not include deferred comp deductions, retirement contributions, or any other payments for NDPERS programs in which you may participate.

Employer Guide Sample

GROUP HEALTH AND LIFE INSURANCE
MONTHLY RECONCILING PROCEDURES

Central Payroll Agencies

The monthly Group Insurance Billings are sent out on the 5th of each month.

Step 1. Verify Coverage. Review the billing to make sure it includes the employees who should have insurance coverage for the billing month. **Do not cross out names on the billing.** To report additions, deletions, or changes that reflect the current month's coverage, use the Adjustments page of the billing. If applications reflecting these changes have not been sent to NDPERS, they must be sent along with the billing for processing. Make changes to level of coverage on the adjustment page as follows:

Additions - Enter Last Name, First Name, Social Security Number and add insurance premium amounts to the amount billed.

Deletions - Enter Last Name, First Name, Social Security Number and subtract insurance premium amounts from the amount billed.

Changes in level of coverage – Record the old level of coverage as a deletion and the new level of coverage as an addition.

The entries on the adjustment page should only be for changes to an employee's insurance coverage for the current month (additions, cancellations, etc).

Step 2. Reconcile payment to billing. Use the PeopleSoft State Detailed Deduction Report or the query NDS_PR165_DEDUCTIONS to determine the premiums that were paid from the advanced and supplemental payrolls. The premiums paid should equal the original amount billed, plus any additions, less any deletions. If the payroll reports do not equal the adjusted billing, you must provide a reconciliation of the premiums paid to the billing as follows. Be sure to include the employee's name, premium amount and month for each adjustment.

Premium payment (from payroll reports)
Add premiums that you owe for the current month, that were not paid
Add personal checks received from employees to pay for current month coverage
Subtract premiums that you paid for the current month that you are requesting a refund for
Subtract premiums that are included in your payment that are for a prior month
Total must equal adjusted billing

Step 3. Return the original billing, along with any personal checks and premium reconciliation to NDPERS by the 15th of each month.

A= Always IA= If Applicable N= Never	Section 1	Section 2	Section 3 - part 1	Effective Date of Coverage	Section 3 - part 2	Section 4	Section 5	Section 6	Employee Section Form	Waiver of Health Coverage	Out of Area Waiver for Dependents	Required Documents	Notice of Transfer	
ENROLLMENT														
Enrolling new contract holder - married, electing coverage	A	A	Elect Basic/PPO or Basic/EPO	Month after event	If currently not covered by BCBS coverage now, indicate "New Coverage". If they do have BCBS coverage, then indicate "Transfer from …"	A	IA	A	IA	N	IA	N		
Enrolling new contract holder - married or single, declining coverage	N	N	N	N	N	N	N	N	N	A	N	N		
Enrolling new contract holder - single female or male	A	A	Elect Basic/PPO or Basic/EPO	Month after event	If currently not covered by BCBS coverage now, indicate "New Coverage". If they do have BCBS coverage, then indicate "Transfer from …"	N	IA	A	IA	N	N	N		
Enrolling new contract holder - "single" female or male, with child(ren)	A	A	Elect Basic/PPO or Basic/EPO	Month after event	If currently not covered by BCBS coverage now, indicate "New Coverage". If they do have BCBS coverage, then indicate "Transfer from …"	A	IA	A	IA	N	IA	State Certified Birth Certificate		
Enrolling new contract holder - "divorced" female or male, with child(ren)	A	A	Elect Basic/PPO or Basic/EPO	Month after event	If currently not covered by BCBS coverage now, indicate "New Coverage". If they do have BCBS coverage, then indicate "Transfer from …"	A	IA	A	IA	N	IA	N		
LIFE CHANGE EVENTS - must complete enrollment form within 31 days of life change event														
Married - changing from single to family coverage - add spouse only	A	A	A - indicate family coverage. Cannot change type of coverage	Month after event	N		IA	A	N	N	N	N		
Married - changing from single to family coverage - add spouse & step child(ren)	A	A	A - indicate family coverage. Cannot change type of coverage	Month after event		A	IA	A	N	N	IA	N		
Married - changing from single to family coverage - add step child(ren) only, spouse NOT currenlty covered by NDPERS	N	N	N	Month after event	N	N	N	N	N	N	N	N		
Married - changing from single to family coverage - add step child(ren) only, spouse currenlty covered by NDPERS	A	A	A - indicate family coverage. Cannot change type of coverage	Month after event	N	A	A	A	N	N	IA	N		
State Employee Married to another State Employee, changing coverage to spouse's NDPERS plan (cannot have 2 State plans).	A	A	A - indicate family coverage. Cannot change type of coverage	Month after event	A - Transfer coverage to employee employed longest with NDPERS. Indicate covered under spouse's NDPERS plan and provide spouse's contract number	A	A	A	N	N	N	Spouse must complete application - see add dependent(s) due to marriage		
State Employee Married to A Political Sub Employee, changing from single to family coverage under the State Employees NDPERS plan. (Cannot have to NDPERS plans.)	A	A	A - indicate family coverage. Cannot change type of coverage	Month after event	A - Indicate covered under spouse's NDPERS plan and provide spouse's contract number	A	A	A	N	N	N			
Birth of a child/adoption - married currently with family coverage	A	A	N	Month in which event occurs	A - indicate add dependent(s) and provide date of birth or adoption	A	IA	A	N	N	IA	IA No Birth Certificate but Placement Papers/Adoption Papers		
Birth of a child/adoption - married currently with single coverage	A	A	A - indicate family coverage. Cannot change type of coverage	Month in which event occurs	A - indicate add dependent(s) and provide date of birth or adoption	A	IA	A	N	N	IA	IA Placement Papers/Adption Papers		
Birth of child/adoption - "single" with single coverage	A	A	A - indicate family coverage. Cannot change type of coverage	Month in which event occurs	A - indicate add dependent(s) and provide date of birth or adoption	A	IA	A	N	N	IA	State Certified Birth Certificate or Placement Papers/Adoption Papers		

A= Always IA= If Applicable N= Never	Section 1	Section 2	Section 3 - part 1	Effective Date of Coverage	Section 3 - part 2	Section 4	Section 5	Section 6	Employee Section Form	Waiver of Health Coverage	Out of Area Waiver for Dependents	Required Documents	Notice of Transfer	
Birth of child/adoption - "divorced" with single coverage	A	A	A - indicate family coverage. Cannot change type of coverage	Month in which event occurs	A - indicate add dependent(s) and provide date of birth or adoption	A	IA	A	N	N	IA	IA Placement Papers/Adoption Papers		
Adding grandchild(ren) to coverage - birth parent currently covered on contract (birth of a grandchild)	A	A	N	Month in which event occurs	A - indicate add dependent and provide date of birth and **indicte dependent parent**	A	IA	A	N	N	IA	If dependent parent is a male a State Certified Birth Certificate is required		
Adding grandchild(ren) to coverage - due to court order	A	A	IA - indicate family coverage. Cannot change type of coverage	Month after event	A - indicate add dependent and provide date of court order	A	IA	A	N	N	IA	Need photocopy of Court Order		
Adding child(ren) within 31 days of a Court Order	A	A	IA - indicate family coverage. Cannot change type of coverage	Month after event	A - indicate add dependent and provide date of court order	A	IA	A	N	N	IA	Provide copy of Court Order		
Adding child(ren) due to a National Medical Support Notice - AUTOMATICALLY DONE BY NDPERS	N/A	N/A	IA - indicate family coverage. Cannot change type of coverage	Month in which event occurs	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NDPERS notified by Child Support Enforcement agency of the order. Record kept on file at PERS & BCBS		
Adding Legal Guardians	A	A	IA - indicate family coverage. Cannot change type of coverage	Month after event	A - indicate add dependent and provide date of court order	A	IA	A	N	N	IA	Need photocopy of Guardianship Papers.		
Adding eligble dependent under age 23 - must be due to a qualifying event	A	A	IA - indicate family coverage. Cannot change type of coverage	Month after event	A - indicate add dependent and provide date of qualifying event	A	IA	A	N	N	IA	IA - Certifcate of Coverage is due to loss of coverage		
Adding eligble dependent under age 23 - due to going back to college	A	A	IA - indicate family coverage. Cannot change type of coverage	Month after event	A - indicate add dependent and provide date of qualifying event	A	IA	A	N	N	IA	Requires a letter from an accredited college to confirm student is full time (12 Credits per semester). Must include date of attendence. CLASS SCHEDULE IS NOT ACCEPTABLE.		
Adding eligble dependent between age 23 and 26 - due to going back to college	A	A	IA - indicate family coverage. Cannot change type of coverage	Month after event	A - indicate add dependent and provide date of returning to college	A	IA	A	N	N	IA	Requires a letter indicating financial dependency and a letter from a accredited college to confirm student is full time (12 credits per semester). Must include date of attendance. CLASS SCHEDULE IS NOT ACCEPTABLE.		
Adding eligible dependent(s) during Annual Enrollment Season (No Qualifying Event)	A	A	IA - indicate family coverage. Cannot change type of coverage	January 1st of upcomin g year	A - indicate add dependent and date change occurred date as July 1	A	IA	A	N	N	IA	N		
Remove child(ren) - due to ineligibility	A	A	IA - indicate level of coverage. Cannot change type of coverage	Month after event	A - indicate remove dependent and date dependent became ineligible	A - list covered dependents including spouse	IA	A	N	N	N	N		
Remove spouse - due to finalization of divorce	A	A	IA - indicate level of coverage. Cannot change type of coverage	Month after event	A - indicate remove dependent and indicate date divorce became final per divorce decree	IA - list covered dependents	IA	A	N	N	IA	IA - Divorce decree required if conflicting information concerning primary coverage for dependent child(ren) or conflicting divorce date		
Remove spouse - due to legal seperation	A	A	IA - indicate level of coverage. Cannot change type of coverage	Month after event	A - indicate remove dependent and indicate date of legal seperation per court document	IA - list covered dependents	IA	A	N	N	IA	A - photocopy of legal seperation		
Remove dependent due to death (including spouse)	A	A	IA - indicate level of coverage. Cannot change type of coverage	Month after event	A - indicate remove dependent due to death and provide date of death	IA - list covered dependents	IA	A	N	N	N	N		
Spouse loss of another employer sponsored plan, new coverage	A	A	Elect Basic/PPO or Basic/EPO	Month after event	If no BCBS coverage now, indicate "New Coverage". If they do have BCBS coverage, then indicate "Transfer from …"	IA - list covered dependents	IA	A	IA	N	IA	Certificate of Insurance from former carrier	N	
Spouse loss of another employer sponsored plan, add spouse/and or children	A	A	IA - indicate level of coverage. Cannot change type of coverage	Month after event	A - indicate add dependent and provide date of qualifying event	IA - list covered dependents	IA	A	N	N	IA	Certificate of Insurance from former carrier		
TRANSFERS														

A= Always IA= If Applicable N= Never	Section 1	Section 2	Section 3 - part 1	Effective Date of Coverage	Section 3 - part 2	Section 4	Section 5	Section 6	Employee Section Form	Waiver of Health Coverage	Out of Area Waiver for Dependents	Required Documents	Notice of Transfer	
Transfer from agency to another agency - includes employees with less than 30 days since last "coverage" date	N	N	N	Month after event	N	N	N	N	N	N	N	N	A	
Transfer from agency to another agency - employees with more than 30 days since last "coverage" date	N	N	N	Month after event	N	N	N	N	N	N	N	Employee is considered a New Hire - see Enrollment section		
ACTIVE DUTY/DISCHARGE														
Remove spouse or dependent child(ren) due to active duty	N	N	N	N	N	N	N	N	N	N	N	Send letter requesting change in coverage to Insurance Division at NDPERS		
Contract holder called to active duty	N	N	N	N	N	N	N	N	N	N	N	Send letter requesting change in coverage to Insurance Division at NDPERS		
Contract holder called to active duty - remaining eligible dependent(s), including spouse, require COBRA coverage	N	N	N	N	N	N	N	N	N	N	N	Send letter requesting change in coverage to Insurance Division at NDPERS		
Contract holder released from active duty, MUST have returned to employment (currently covered with TriCare)	A	A	Elect Basic/PPO or Basic/EPO	Month in which event occurs		IA - list covered dependents	IA	A	A	N	IA	Provide copy of discharge papers (DD214 or NGB22)		
CANCEL/CHANGE INSURANCE COVERAGE														
Married, changing coverage to spouse's NDPERS plan (cannot have 2 State plans).	A	A	A - indicate covered under spouse's NDPERS plan and provide spouse's contract number	Month after event	N	N	N	A	N	N	N	Spouse must complete application - see add dependent(s) due to marriage		
Married, changing coverage to spouse's NDPERS plan due to retirement of contract holder	A	A	A - indicate covered under spouse's NDPERS plan and provide spouse's contract number	Month after event	N	N	A - indicate reason as retirement	A	N	N	N	Spouse must complete application - see add dependent(s) due to qualifying event		
Due to terminiation of employment	N	N	N	Month after event	N	N	N	N	N	N	N	Complete Continuation of Group Health Insurance Coverage (CORBA) SFN 14120		
Due to retirement	N	N	N	Month after event	N	N	N	N	N	N	N	See Retirement Kit		