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