State Life Insurability Kit

Provider: VOYA

APPLY WITHIN: 31 DAYS OF A LIFESTYLE CHANGE, WITHIN 31 DAYS OF EMPLOYMENT FOR COVERAGE OVER THE GUARANTEE ISSUE AMOUNT OR DURING THE ANNUAL OPEN ENROLLMENT

1. Complete the Life Insurance Enrollment/Change form indicating the total amount of coverage you want to have.

2. Complete Evidence of Insurability form:

   - Complete all three pages. You must answer medical questions for each person applying for coverage.
   - Print your name and SS# on top of pages 2 & 3.
   - Employee signature is always required on page 3. Spouse signature is also required if they are applying for coverage.

3. Return the State Life Insurability Kit to the UND Payroll Office - Stop 7127 or Twamley Rm 409. Off campus please mail the kit to UND Payroll Office, 264 Centennial Drive Stop 7127, Grand Forks, ND 58202. Completed forms may also be emailed to brandi.byrne@und.edu.

If you have questions regarding this paperwork please call 701-777-2158.

STATE LIFE INSURANCE RATES

Term Life Insurance

Underwritten by **VOYA**

- **Basic Life** - $12,000 (employer paid).
- **Employee Supplemental -** Up to $300,000 without medical approval in $5,000 increments within 31 days of hire date. **Coverage over $300,000 (maximum of $600,000) must be medically approved.** Coverage includes the $12,000 basic. All coverage must be medically approved after 31 days of employment.
- **Spouse Supplemental** - Up to $100,000 without medical approval. Spouse coverage is limited to 50% of total employee supplemental. **Coverage over $100,000 (maximum of $300,000) must be medically approved within 31 days of hire.**
  Employee supplemental and dependent coverage are required. All coverage must be medically approved after 31 days of employment.
- **Dependent** - $2,000, $5,000, $7,000 or $10,000 - (covers spouse and unmarried children from birth but less than 26 years of age). **Employee supplemental is required.**
- **If both husband and wife are UND employees** - Dependents and spouse **may** be insured by both members.

Monthly Rates

Employee Age	Employee / Spouse: Rate is based on employee's age	Dependent		
	Per $1,000 coverage	Spouse	Children	Rate
Under 25	0.02 / 0.02	$2,000	$2,000	.20 per month
25-29	0.02 / 0.02	$5,000	$5,000	.50 per month
30-34	0.04 / 0.04	$7,000	$7,000	.70 per month
35-39	0.06 / 0.06	$10,000	$10,000	$1.00 per month
40-44	0.08 / 0.08	Dependent rate is not age based. It is a flat rate per month no matter how many dependents you are covering.		
45-49	0.09 / 0.10			
50-54	0.15 / 0.16			
55-59	0.30 / 0.32			
60-64	0.47 / 0.50			
65-69	0.92 / 0.98			
70+	1.52 / 1.60			

Upon termination of employment Voya will send the employee information to continue the coverage.

For further information, contact the Payroll Office at 701-777-2158.

53803

LIFE INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53803 (Rev. 04-2023)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

Underwritten by Voya Financial (Carrier) Policy Number: 67389-7

PART A EMPLOYER/EMPLOYMENT STATUS

Organization Name	NDPERS Organization ID	Employment Status ☐ Active Full-Time ☐ Active Part-Time

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

☐ New Hire (Date of Hire_____/_____/_____) ☐ New Employer Group

☐ Annual Enrollment-Read below for Evidence of Insurability (EOI) requirements

☐ Decrease Coverage ☐ Marital Status Change (Date of Change _____/_____/_____)

☐ Birth/Adoption (Date of Change_____/_____/_____)

Effective Date

_____/01/20____

PART B EMPLOYEE INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last 4 Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Personal Email Address	Telephone Number

PART C EMPLOYEE COVERAGE

Basic Life ☒ Employee Only—Employer Provides $12,000 of Basic Life Coverage at no expense to you
(Temporary employees electing coverage are responsible for basic life premium)

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 $300,000 without evidence of insurability (EOI). You can request coverage above the GI Limit to a maximum of $600,000, but must submit EOI. You are subject to approval by the carrier for the amount above GI. During annual enrollment, you can increase your existing employee supplemental by up to a $25,000 increment without EOI up to the GI Limit. EOI must be completed for newly electing employee supplemental (only have Basic $12,000), increases larger than $25,000, or requests above the GI Limit and are subject to approval by the Carrier.

☐ I am applying for a TOTAL (include Basic Life in total) supplemental life coverage of $_____ (Increments of $5,000)

☐ Waive Additional Supplemental Life & AD&D coverage

PART D DEPENDENT COVERAGE

Supplemental Dependent Life Insurance Election: Only available if you elected Supplemental in Part C. When you are initially eligible for dependent coverage or during annual enrollment, you can elect it without providing evidence of insurability.

☐ $10,000 for eligible spouse and $10,000 for each eligible dependent child. **OR**
☐ $7,000 for eligible spouse and $7,000 for each eligible dependent child. **OR**
☐ $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. **OR**
☐ Waive Supplemental Dependent Coverage

PART E SPOUSE COVERAGE

Supplemental Spouse Life Election: Only available if you elected dependent coverage in Part D. When you are initially eligible for supplemental spouse coverage, you can elect up to $100,000 in coverage without providing evidence of insurability. Total spouse coverage up to $300,000 is available if your spouse completes an Evidence of Insurability form (EOI) for approval by the Carrier. **Supplemental spouse coverage is limited to 50% of the employee's coverage amount.** Upon a qualifying event or annual enrollment, an Evidence of Insurability form (EOI) must be completed.

☐ **Total Amount of coverage** $_____ (Increments of $5,000)

Name	**Date of Birth(mm/dd/yyyy)**

☐ Waive Supplemental Spouse Coverage

PART F BENEFICIARY INFORMATION

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855

Part G AUTHORIZATION AND INSTRUCTIONS

I acknowledge I have read the authorization on page 2 of SFN 53803.

Employee's Signature (Electronic Signature will not be accepted)	Date

PART G AUTHORIZATION

READ THIS INFORMATION CAREFULLY AND SIGN THIS FORM ON PAGE 1 BEFORE SUBMITTING IT TO NDPERS.

- 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 Carrier, provided I am actively at work.
- I understand that evidence of insurability may be required for coverage to become effective.

INSTRUCTIONS

Part A Employer/Employment Status

Must be completed by your employer's authorized agent.

Part B Employee Information

For member identification, please provide all requested information.

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. Indicate the TOTAL amount of coverage you are requesting.

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.

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.

Part F Beneficiary Information

To designate your beneficiary(ies), you must complete and submit a Life Insurance Designation of Beneficiary SFN 53855.
IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part G Authorization

You must sign and date this this form to be valid. Electronic Signature will not be accepted.

EVIDENCE OF INSURABILITY (ND)

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
PO Box 20, Mail Stop 5-E, Minneapolis, MN 55440
Phone: 612.342.7262 Fax: 612.467.8721

Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number **673897** Account Number **1** Employer Name **NDPERS**

Option 1 _____ Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female

SSN _____ Personal Email Address _____ Birth Date _____

Address _____ City _____ State _____ ZIP _____

Home Phone (_____)_____ Cell Phone (_____)_____

Hire Date _____ Salary $_____ Occupation _____

Primary Health Practitioner _____ Practitioner Phone (_____)_____

Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS *(Complete this table based only on the coverage you have through this plan.)*

Are you completing this form due to a Family Status Change *(Marriage, Divorce, Birth, Adoption, etc.)*? ☐ Yes ☐ No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
☐ Employee Supplemental Life	$	$	$	$
☐ Spouse Supplemental Life	$	$	$	$

C. SPOUSE INFORMATION

Spouse Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female

SSN _____ Personal Email Address _____ Birth Date _____

Home Phone (_____)_____ Cell Phone (_____)_____

☐ Same Primary Health Practitioner as Employee *(See information above.)*

Primary Health Practitioner _____ Practitioner Phone (_____)_____

Practitioner Address _____ City _____ State _____ ZIP _____

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Employee Name _____ SSN ***(Last 4 digits only.)*** _____

D. EMPLOYEE AND SPOUSE HEALTH QUESTIONS *(Must be answered for coverage that is not Guaranteed Issue.)*

Employee (EE) Yes	Employee (EE) No	Spouse (SP) Yes	Spouse (SP) No	
☐	☐	☐	☐	1. Have you ever been diagnosed or treated by a member of the medical profession as having AIDS, ARC, or the HIV infection?
☐	☐	☐	☐	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/ angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP. --->				3. **Employee:** Height _____ ft. _____ in. Weight _____ lbs. **Spouse:** Height _____ ft. _____ in. Weight _____ lbs.
				4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
☐	☐	☐	☐	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
☐	☐	☐	☐	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
☐	☐	☐	☐	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
☐	☐	☐	☐	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
☐	☐	☐	☐	e. Polycystic kidney disease or kidney failure?
				5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
☐	☐	☐	☐	a. Chest pain, heart trouble or circulatory disorder?
☐	☐	☐	☐	b. Anemia or leukemia?
☐	☐	☐	☐	c. Sleep apnea, asthma or other respiratory disorder?
☐	☐	☐	☐	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
☐	☐	☐	☐	e. Stomach disorder?
☐	☐	☐	☐	f. Brain or seizure disorder?
☐	☐	☐	☐	g. Mental or nervous disorder?
☐	☐	☐	☐	h. Arthritis, paralysis or any muscle weakness?
☐	☐	☐	☐	i. Abnormal urine specimen or urinary tract disorder?
☐	☐	☐	☐	j. Prostate or other reproductive organ disorder?
☐	☐	☐	☐	6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
☐	☐	☐	☐	7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
☐	☐	☐	☐	8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
☐	☐	☐	☐	9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

For every "Yes" answer, to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	

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Employee Name _____ SSN ***(Last 4 digits only.)*** _____

E. AUTHORIZATION AND ACKNOWLEDGMENT *(Please read and sign below)*

For underwriting and claim purposes, I give my permission to any blood bank, blood center, plasma center, health care provider, any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations–42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

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

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.
I declare that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

Return completed EOI to your payroll/HR Office for forwarding to NDPERS.

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CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures
For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices
Collecting Information
Your application or claim form is our main source of information. But we may:
- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports
Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use
We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure
We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information
If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.
We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.