WAIVER OF RETIREMENT AND HEALTH INSURANCE PARTICIPATION FOR TEMPORARY OR PART-TIME OR STUDENT EMPLOYEES

RETIREMENT

I understand that I am eligible in the North Dakota Public Employees Retirement System (NDPERS) as a temporary/part-time/student employee. If I elect to participate, I will be obligated to contribute monthly contributions equal to 9.12% of my gross monthly salary to the plan. The 9.12% of gross salary can be deducted from each paycheck or payment can be made to the Payroll Office by the 6th day of the month for the previous month's salary. Failure to remain current on payments to the retirement plan may result in loss of eligibility to participate in the future. I understand that I will not have access to these funds for any reason while I am eligible to participate. If I terminate my employment and take a refund of my retirement monies, I understand that I will not be allowed to participate in NDPERS through future employment as a temporary/part-time/student employee. I understand that I cannot elect to participate in NDPERS as a part-time/temporary employee if I am actively contributing to another employer sponsored pension fund (public or private).

_____ I elect to participate and certify that I am eligible under NDCC 54-52-02.9 to participate in the NDPERS. This form must be accompanied by a membership enrollment form (SFN 2561) and a Designation of Beneficiary Form (SFN 2560).

_____ I decline to participate. I understand that I can only elect to participate in the NDPERS as a temporary/part-time/student employee within the first six months of employment or within six months of a change in status from permanent/full-time to temporary/part-time/student.

_____	_____	_____
Signature of Employee	Social Security Number	Date

HEALTH INSURANCE

I understand 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**. (You may contact the WSC Human Resource Dept. to obtain monthly rates.)** If I elect to participate, I understand that I will be billed for the premium on a monthly basis. I understand I may enroll at a later date, if I do so within 31 days of one of the following events: (1) loss of health coverage from another source; or (2) to add a new dependent as a result of marriage, birth, adoption or placement for adoption. I may apply as a Late Enrollee if I request membership during the May open enrollment period and may be subject to a twelve month waiting period for pre-existing conditions.

_____ I elect to participate in the Health Benefit Plan. This form must be accompanied by a completed Health Insurance Application.

_____ I am declining health insurance coverage, at this time.

_____	_____	_____
Signature of Employee	Social Security Number	Date

An acceptance or decline and a signature is required for each section. If you have any questions regarding either of these waivers or if you need enrollment forms, please contact the Business Office.