Standard Insurance Company
888.288.1270 Tel

Voluntary Life and Voluntary Short Term Disability
Enrollment and Change Form For Active Employees

Check all box(es) and complete all sections that apply. Mail completed form to the address listed below.

MEMBER INFORMATION

Enrollment
- ☐ Initial Enrollment
- ☐ Late Applicant
- ☐ Rehire/Reinstatement

Change
- ☐ Increase Coverage
- ☐ Terminate Coverage
- ☐ Reduce Coverage
- ☐ Add Dependent
- ☐ Delete Dependent
- ☐ Other________________
- ☐ Address Change
- ☐ Date add/delete________
- ☐ Name Change

Group Name				
State of Nevada Public Employees' Benefits Program			Group Number: 642682	
Agency Name	Agency Phone Number		Agency Type: ☐ State ☐ Non-State	
Your Name (Last, First, Middle)			If name change, what was your former name?	
Your Mailing Address	City		State	Zip	Home Phone
Date of Birth	Gender: ☐ Male ☐ Female	Date of Hire	Soc. Sec. No.	

ARE YOU ENROLLED IN THE STATE OF NEVADA PEBP SPONSORED MEDICAL PLAN? ☐ **YES** ☐ **NO**

DISABILITY

VOLUNTARY SHORT TERM DISABILITY

☐ **Option A** (7-day Benefit Waiting Period) ☐ **Option B** (14-day Benefit Waiting Period) ☐ **Option C** (30-day Benefit Waiting Period)

Annual Salary $ ____________ Are you currently enrolled in a Short Term Disability program? ☐ YES ☐ NO

Please Note: Annual salary is mandatory for processing this application.

VOLUNTARY LIFE

If you are enrolled in the State of Nevada PEBP Sponsored Medical Plan, PEBP provides you with $25,000 of Basic Life coverage. You may elect additional life insurance for yourself and dependents by indicating below. Check with your Human Resources Department about eligibility, dependent eligibility, and Evidence of Insurability requirements.

VOLUNTARY LIFE AND AD&D INSURANCE

☐ **Employee** *(Multiples of $5,000 to $500,000)*

Please note: Current Voluntary Life amount does not include Basic Life amount provided by the State.

$25,000 (Basic Life Insurance Amount) + ____________ (Current Voluntary Life Amount with **The Standard**) + ____________ (Additional Amount Requested) = ____________ (Total Amount Requested)

DEPENDENTS VOLUNTARY LIFE INSURANCE

☐ **Spouse/Domestic Partner** *(Multiples of $5,000 to $250,000, not to exceed 100% of your combined Basic and Voluntary Life coverage)*

$ ____________ (Current Dependents Voluntary Life Amount with The Standard) + ____________ (Additional Amount Requested) = ____________ (Total Amount Requested)

Spouse/Domestic Partner Date of Birth ____________

☐ **Dependent Children Voluntary Life** *(Please select one)*

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

SIGNATURE

I wish to apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member Signature Required	Date (Mo/Day/Yr)

INSTRUCTIONS

Please return completed form in the enclosed self-addressed envelope:

State of Nevada Life Insurance Team
Mestmaker Insurance Services
P.O. Box 2302
Bakersfield, CA 93303-2302

Please retain a copy for your records.