State of Nevada
Public Employees' Benefits Program

775-684-7000
1-800-326-5496

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

pebp.state.nv.us

Retiree Benefit Enrollment and Change Form

1 Choose one of the following events:

- ☐ Retirement
- ☐ Survivor Election
- ☐ Address Change
- ☐ Marriage
- ☐ Divorce
- ☐ Death of Dependent
- ☐ Name Change
- ☐ Birth or Adoption
- ☐ Disabled Retiree
- ☐ Medicare Eligibility Change
- ☐ Dependent Gains Own Coverage
- ☐ Dependent Loses Own Coverage
- ☐ Move Outside Coverage Area
- ☐ COBRA Election Med/Dent/Vision
- ☐ Terminate Domestic Partnership
- ☐ Establish Domestic Partnership

Date of Event ___ - ___ - ____

2 Participant Information

Please Print Clearly and Legibly - Use Blue or Black Ink Only

Social Security Number ___ - ___ - ____ Date of Birth ___ - ___ - ____ ☐ Male ☐ Female

Last Name First Name MI

Street Number Street Name or P.O. Box Apt Number

City State Zip Code -

Home Phone ___ - ___ - ____ Work Phone ___ - ___ - ____

E-mail Address

3 Select Your Healthcare Coverage. MARK ONLY ONE Box In This Section.

PPO Option

☐ Consumer Driven Health Plan includes Health Reimbursement Arrangement [HRA]

Medicare Exchange Option

☐ Exchange with PEBP Dental Coverage includes Health Reimbursement Arrangement [HRA] for all except Survivors

☐ Exchange without PEBP Dental Coverage includes Health Reimbursement Arrangement [HRA] for all except Survivors

HMO/EPO Option

Northern Nevada EPO

☐ PEBP Premier Plan

Southern Nevada HMO

☐ Health Plan of Nevada HMO

Decline Coverage

☐ I Decline/Waive Coverage for Health insurance, HRA Funding and Life insurance (if applicable).

4 If you have selected HMO coverage, please indicate Primary Care Physician Codes; otherwise, go to section 5.

Participant's Physician Code Spouse or DP Physician Code Children's Physician Code

Physician Codes can be found on the PEBP website at pebp.state.nv.us.

5 Choose Coverage For:

☐ Participant Only ☐ Participant + Spouse ☐ Participant + Participant's Children ☐ Participant + Family

☐ Participant + Domestic Partner (DP) ☐ Participant + DP's Children ☐ Participant + DP + Participant's Children + DP's Children

☐ Participant + Participant's Children + DP's Children ☐ Participant + DP + DP's Children ☐ Participant + DP + Participant's Children

6 Do you have [choose all that apply]: Medicare A? ☐ Yes Medicare B? ☐ Yes Medicare D? ☐ Yes

If your Spouse/DP is covered as a dependent, do they have [choose all that apply]: Spouse/DP Medicare A? ☐ Yes Spouse/DP Medicare B? ☐ Yes Spouse/DP Medicare D? ☐ Yes

Please Sign and Date on Reverse

PEBP Use Only

pebp.state.nv.us

Supporting Documentation For Dependent Coverage Will Be Required.

(7) List only eligible new dependents, dependents to be deleted, OR current dependents who require a status CHANGE.

☐ Add ☐ Dependent applies for own coverage ☐ Delete ☐ Change

Social Security Number ___ - __ - ____ Date of Birth __ - __ - ____ ☐ Male ☐ Female

Last Name First Name MI

☐ Spouse ☐ Domestic Partner (DP) ☐ Participant's Child ☐ DP's Child ☐ Step Child ☐ Legal Guardianship ☐ Disabled Dependent Child

☐ Add ☐ Dependent applies for own coverage ☐ Delete ☐ Change

Social Security Number ___ - __ - ____ Date of Birth __ - __ - ____ ☐ Male ☐ Female

Last Name First Name MI

☐ Spouse ☐ Domestic Partner (DP) ☐ Participant's Child ☐ DP's Child ☐ Step Child ☐ Legal Guardianship ☐ Disabled Dependent Child

☐ Add ☐ Dependent applies for own coverage ☐ Delete ☐ Change

Social Security Number ___ - __ - ____ Date of Birth __ - __ - ____ ☐ Male ☐ Female

Last Name First Name MI

☐ Spouse ☐ Domestic Partner (DP) ☐ Participant's Child ☐ DP's Child ☐ Step Child ☐ Legal Guardianship ☐ Disabled Dependent Child

☐ Add ☐ Dependent applies for own coverage ☐ Delete ☐ Change

Social Security Number ___ - __ - ____ Date of Birth __ - __ - ____ ☐ Male ☐ Female

Last Name First Name MI

☐ Spouse ☐ Domestic Partner (DP) ☐ Participant's Child ☐ DP's Child ☐ Step Child ☐ Legal Guardianship ☐ Disabled Dependent Child

☐ Add ☐ Dependent applies for own coverage ☐ Delete ☐ Change

Social Security Number ___ - __ - ____ Date of Birth __ - __ - ____ ☐ Male ☐ Female

Last Name First Name MI

☐ Spouse ☐ Domestic Partner (DP) ☐ Participant's Child ☐ DP's Child ☐ Step Child ☐ Legal Guardianship ☐ Disabled Dependent Child

☐ Add ☐ Dependent applies for own coverage ☐ Delete ☐ Change

Social Security Number ___ - __ - ____ Date of Birth __ - __ - ____ ☐ Male ☐ Female

Last Name First Name MI

☐ Spouse ☐ Domestic Partner (DP) ☐ Participant's Child ☐ DP's Child ☐ Step Child ☐ Legal Guardianship ☐ Disabled Dependent Child

(8) AUTHORIZATION

I understand I am applying to PEBP for coverage for myself, my spouse and/or my dependents, if any, as shown on this form. If electing dependent coverage, I also understand that I am required to supply copies of certified birth certificate(s), marriage certificate, and other related documentation as determined by PEBP, for coverage to become effective. My spouse or DP, if any, is not eligible to participate in any employer provided medical plan maintained by my spouse's or DP's current employer. I understand that any misstatements on this form may be used as a basis for rescission of insurance for me and my dependents, if any, from the original effective date. I further understand that if the insurance applied for becomes effective, I will be subject to all the terms of the PEBP Master Plan Document. I hereby authorize PERS to deduct any required contributions from my retirement check, if applicable, for the coverage I have selected. I certify, under penalty of perjury, that the above answers and information are true and that I have read and understand the authorization on this form.

Signature: ____________________ Date: __ - __ - ____

Retirees Please Return To:
Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, NV 89701 OR
Email memberservices@peb.nv.gov

pebp.state.nv.us *Please Sign and Date*

State of Nevada
Public Employees' Benefits Program

775-684-7000
1-800-326-5496

Nevada PUBLIC EMPLOYEES BENEFITS PROGRAM
PEBP
Health Matters

pebp.state.nv.us

Years of Service Certification

Please Print Clearly and Legibly - Use Blue or Black Ink Only

(1) Participant Information

As a retired public employee, you may qualify for a premium subsidy based on each Nevada public employer with whom you earned service credit. In order to apply for a subsidy toward your retiree health insurance premium, this form must be received in the PEBP office by the last business day of the month prior to the start of your retiree coverage. A subsidy will be applied to your premium cost upon the commencement of your retirement coverage or on the first month following submission of this form, whichever is later. The "First Day Retired" entered on this form is the first day you are in retirement status with your retirement plan.

Social Security Number ___-___-____ **Date of Birth** __-__-____ ☐ Male ☐ Female

Last Name _____ **First Name** _____ **MI** ___

First Day Retired __-__-____

(2) Enter the employer code and full name of each of your former Nevada public employers.

Employer codes are included on the enclosed list. If your former employer is not on the list, please write in the full name of the employer without a code. Please list in descending order, starting with the name of your most recent Nevada public employer.

(3) List the number of years and months you worked for each Nevada public employer.

Do not round days up to the next month. Do not round a month up to the next year. Example: You worked for the City of Las Vegas from 03-26-82 (Mar 1982) to 03-17-88 (Mar 1988). This is equal to 5 years and 11 months of service.

Employer Code	Employer Name	Years	Months
____		__	__
____		__	__
____		__	__
____		__	__
____		__	__
____		__	__

(4) Enter any service credit that was purchased by you or on your behalf:

Purchased Years __ / Months __

I acknowledge that the information provided is true. I understand that PEBP may verify this information with my retirement plan(s).

Signature: _____ **Date:** __-__-____

Please Return To:
Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, NV 89701 OR
Email memberservices@peb.nv.gov