

Public Employees' Benefits Program

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Phone: 775-684-7000 or 1-800-326-5496



**Benefit Enrollment and
Change Form Unsubsidized**

Effective Date of Change (MM/DD/YYYY)

1. This form is only for the following event:

Dependent Conversion to Unsubsidized Participant

Unsubsidized dependent coverage is limited to medical, prescription drug, vision, dental, and [if eligible] the Health Reimbursement Arrangement contribution. Coverage does not include basic life insurance, Medicare Part B credit or any financial credit to premium, including the years of service subsidy.

2. Participant Information (Please Print Clearly and Legibly)

Social Security Number (XXX-XX-XXXX)		Date of Birth (MM/DD/YYYY)		Male	Female
Last Name		First Name		Middle Initial	
Address Line 1		Primary Phone Number (Home or Cell)			
Address Line 2		Alternate or Work Phone Number			
City	State	Zip Code	Email (Work or Personal)		

3. Select Your Healthcare Coverage. Mark Only One Box In This Section

Consumer Driven Health Plan (CDHP-PPO) Includes Health Reimbursement Arrangement (HRA)	<u>Medicare Exchange - Includes HRA for Eligible Retirees Only</u> WITH PEBP Dental Coverage	I Decline/Waive Coverage for Health Insurance, HRA Funding, Life Insurance and Voluntary Benefits (if applicable)
Low Deductible PPO (LD-PPO)	WITHOUT PEBP Dental Coverage	
PEBP Premier Plan (Northern Nevada EPO)	TRICARE for Life - WITH PEBP Dental Coverage	
Health Plan of Nevada (Southern Nevada HMO)	TRICARE for Life - WITHOUT PEBP Dental Coverage	

4. Choose Coverage For:

- Unsubsidized Participant Only
- Unsubsidized Participant + Unsubsidized Participant's Child(ren)
- Unsubsidized Participant + DP's Children
- Unsubsidized Participant + Unsubsidized Participant's Child(ren) + DP's Child(ren)

5. Do You and/or a Covered Dependent Have (Choose All That Apply or skip):

<u>YOU</u>	<u>CHILD</u>	Please provide PEBP with a copy of any applicable Medicare A+B Card; and if applicable, a copy of the front and back of the Military ID Card for TRICARE. If you are ineligible for premium free Medicare Part A please provide a copy of your Social Security Benefits Verification Letter. You may skip this section if not applicable.
Medicare Part A?		
Medicare Part B?		
Medicare Part D?		
TRICARE for Life?		



PEBP USE ONLY

Supporting Documentation For Dependent Coverage Will Be Required.

List only eligible new dependents, dependents to be deleted, or current dependents who require a status change.

	Social Security Number	Date of Birth (MM/DD/YYYY)	
Add			Male Female
Delete	Last Name	First Name	Middle Initial
Change			
<hr/>			
Participant's Child	DP's Child	Step Child	Legal Guardianship Disabled Dependent Child

	Social Security Number	Date of Birth (MM/DD/YYYY)	
Add			Male Female
Delete	Last Name	First Name	Middle Initial
Change			
<hr/>			
Participant's Child	DP's Child	Step Child	Legal Guardianship Disabled Dependent Child

	Social Security Number	Date of Birth (MM/DD/YYYY)	
Add			Male Female
Delete	Last Name	First Name	Middle Initial
Change			
<hr/>			
Participant's Child	DP's Child	Step Child	Legal Guardianship Disabled Dependent Child

	Social Security Number	Date of Birth (MM/DD/YYYY)	
Add			Male Female
Delete	Last Name	First Name	Middle Initial
Change			
<hr/>			
Participant's Child	DP's Child	Step Child	Legal Guardianship Disabled Dependent Child

	Social Security Number	Date of Birth (MM/DD/YYYY)	
Add			Male Female
Delete	Last Name	First Name	Middle Initial
Change			
<hr/>			
Participant's Child	DP's Child	Step Child	Legal Guardianship Disabled Dependent Child

AUTHORIZATION

I understand I am applying to PEBP for coverage for myself, and my eligible dependent(s), 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. 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 understand that as an unsubsidized dependent I am limited to medical, prescription drug, vision, dental, and [if eligible] the Health Reimbursement Arrangement contribution. Coverage does not include basic life insurance, Medicare Part B credit or any financial credit to premium, including the years of service subsidy. 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** _____

Please **SIGN and DATE** and return to PEBP by mail **-OR-** online, doing both may delay enrollment.