Public Employees' Benefits Program
3427 Goni Road, Suite 109
Carson City, NV 89706

https://pebp.nv.gov
Email: memberservices@peb.nv.gov
Phone: 775-684-7000, 702-486-3100, or
1-800-326-5496

Reinstatement Late Enrollment Plan Year 2025

Coverage Effective July 1, 2024

Fill out this form ONLY if you are completing a Reinstatement Late Enrollment. A Years of Service Form will also be required.

1. 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)

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

PPO Options

Consumer Driven Health Plan (CDHP-PPO)
Includes Health Reimbursement Arrangement (HRA)

Low Deductible Plan (LD-PPO)

EPO/HMO Option

Northern Nevada (EPO)

Plan Southern Nevada (HMO): Health Plan of Nevada

Decline Coverage

I Decline/Waive Coverage for Health Insurance, Life Insurance, and voluntary Benefits (if applicable)

Medicare Exchange Option

Exchange w/ PEBP Dental Coverage

Exchange w/out PEBP Dental Coverage

TRICARE Option

TRICARE w/ PEBP Dental Coverage

TRICARE w/out PEBP Dental Coverage

If you select one of the above options,you must also submit a copy of your (and any applicable dependents) Medicare A+B Card and Military ID (if applicable)

3. Choose Coverage For:

Participant Only

Participant + Spouse (P+S)

Participant + Participant's Child(ren) (P+C)

Participant + Family (P+F)

Participant + Domestic Partner (P+DP)

Participant + DP's Child(ren) (P+C)

Participant + DP's Child(ren) + Participant's Child(ren) (P+C)

Participant + DP + DP's Child(ren) (P+F)

Participant + DP + Participant's Child(ren) (P+F)

Participant + DP + DP's Child(ren) + Participant's Child(ren) (P+F)

Visit https://pebp.nv.gov to review plan documents

Please SIGN and DATE the back of this form and return to PEBP by mail -OR- online, doing both may delay enrollment.
Incomplete or incorrect forms will be returned.

Properly completed forms must be received in the PEBP office no later than May 31, 2024.

Please Return To:

Secure Document Upload:
https://pebp.nv.gov/Contact/contact-us/

-OR-

Mail:
Public Employees' Benefits Program
3427 Goni Road, Suite 109
Carson City, NV 89706

Supporting Documentation For Dependent Coverage Are Required by June 15, 2024.

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

Add
Delete
Change

Social Security Number | Date of Birth (MM/DD/YYYY) | Male | Female

Last Name | First Name | Middle Initial

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

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Add
Delete
Change

Social Security Number | Date of Birth (MM/DD/YYYY) | Male | Female

Last Name | First Name | Middle Initial

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

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Add
Delete
Change

Social Security Number | Date of Birth (MM/DD/YYYY) | Male | Female

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

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Add
Delete
Change

Social Security Number | Date of Birth (MM/DD/YYYY) | Male | Female

Last Name | First Name | Middle Initial

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

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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 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** ______________

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