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

Public Employees' Benefits Program

Reinstatement Late Enrollment Plan Year 2026

Coverage Effective July 1, 2025

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:

If you are not yet enrolled with Via Benefits you must come back onto a PEBP plan for the month of July to re-enroll in a qualified medical plan with Via Benefits effective August 1st. Select one of the PEBP plans below in addition to a Medicare option. If you are already enrolled with Via Benefits or TRICARE for Life, select only a Medicare option. You must also submit a copy of your, and any dependent(s), Medicare A+B card and Military ID (if applicable).

PEBP Plan Options:

- ☐ Consumer Driven Health Plan (CDHP-PPO)
  Includes Health Reimbursement Arrangement (HRA)
- ☐ Low Deductible Plan (LD-PPO)
- ☐ Northern Nevada (EPO):Exclusive Provider Organization Plan
- ☐ Southern Nevada (HMO): Health Plan of Nevada

Medicare Options:

- ☐ Exchange w/ PEBP Dental Coverage
- ☐ Exchange w/out PEBP Dental Coverage
- ☐ TRICARE w/ PEBP Dental Coverage
- ☐ TRICARE w/out PEBP Dental Coverage

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, 2025.

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, 2025.

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

---

☐ 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

---

☐ 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

---

☐ 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

---

☐ 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

---

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.