

**Public Employees' Benefits Program**

3427 Goni Road, Suite 109  
Carson City, NV 89706

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Email: memberservices@pebp.nv.gov  
Phone: 775-684-7000, 702-486-3100 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) Low Deductible PPO (LD-PPO)	<b><u>Medicare Exchange - Includes HRA for Eligible Retirees Only</u></b> <b>WITH</b> PEBP Dental Coverage <b>WITHOUT</b> PEBP Dental Coverage TRICARE for Life - <b>WITH</b> PEBP Dental Coverage TRICARE for Life - <b>WITHOUT</b> PEBP Dental Coverage	I Decline/Waive Coverage for Health Insurance, HRA Funding, Life Insurance and Voluntary Benefits (if applicable)
PEBP Exclusive Provider Organization Plan (Northern Nevada EPO)		
Health Plan of Nevada (Southern Nevada HMO)		

**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):**

<b><u>YOU</u></b>	<b><u>CHILD</u></b>	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.
Medicare Part A?	Medicare Part B?	
Medicare Part D?		If you are ineligible for premium free Medicare Part A please provide a copy of your Social Security Benefits Verification Letter.
TRICARE for Life?		You may skip this section if not applicable.



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								
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Participant's Child</td> <td style="width: 15%;">DP's Child</td> <td style="width: 15%;">Step Child</td> <td style="width: 15%;">Legal Guardianship</td> <td style="width: 35%;">Disabled Dependent Child</td> </tr> </table>				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, 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.