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

Retiree Benefit Enrollment and Change Form

Please note: You may be subject to a gap in health insurance benefits if your PERS retirement date is different than the termination date provided to PEBP by your employer.

Effective Date of Change (MM/DD/YYYY)

1. Choose one of the following events:

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

2. Participant Information (Please Print Clearly and Legibly)

Social Security Number (Please enter without dashes)

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)
- ☐ PEBP Exclusive Provider Organization Plan (Northern Nevada EPO)
- ☐ Health Plan of Nevada (Southern Nevada HMO)

Medicare Exchange - Includes HRA for Eligible Retirees Only

- ☐ **WITH** PEBP Dental Coverage
- ☐ **WITHOUT** PEBP Dental Coverage
- ☐ TRICARE for Life - **WITH** PEBP Dental Coverage
- ☐ TRICARE for Life - **WITHOUT** PEBP Dental Coverage

- ☐ I Decline/Waive Coverage for Health Insurance, HRA Funding, Life Insurance and Voluntary Benefits (if applicable)

4. 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)

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

	YOU	SPOUSE/DP	CHILD
Medicare Part A?	☐	☐	☐
Medicare Part B?	☐	☐	☐
Medicare Part D?	☐	☐	☐
TRICARE for Life?	☐	☐	☐

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.

PEBP USE ONLY

PLEASE BE SURE TO **SIGN AND DATE** 2nd PAGE BEFORE RETURNING TO PEBP. INCOMPLETE OR INCORRECT FORMS WILL BE RETURNED.

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.

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

Last Name | First Name | Middle Initial

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

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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, 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. 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.