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

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)

☐ 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:

☐ 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):

	YOU	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 ______

☐ 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 ______

☐ 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 ______

☐ 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 ______

☐ 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 ______

☐ 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.