

Check all box(es) and complete all sections that apply. Mail completed form to the address listed below.

MEMBER INFORMATION	<table style="width:100%; border: none;"> <tr> <td style="width: 25%;">Enrollment</td> <td colspan="3">Change</td> </tr> <tr> <td><input type="checkbox"/> Initial Enrollment</td> <td><input type="checkbox"/> Increase Coverage</td> <td><input type="checkbox"/> Address Change</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Late Applicant</td> <td><input type="checkbox"/> Reduce Coverage</td> <td colspan="2"><input type="checkbox"/> Name Change</td> </tr> <tr> <td></td> <td colspan="3"><input type="checkbox"/> Terminate Coverage</td> </tr> </table>				Enrollment	Change			<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Increase Coverage	<input type="checkbox"/> Address Change	<input type="checkbox"/> Other _____	<input type="checkbox"/> Late Applicant	<input type="checkbox"/> Reduce Coverage	<input type="checkbox"/> Name Change			<input type="checkbox"/> Terminate Coverage		
	Enrollment	Change																		
	<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Increase Coverage	<input type="checkbox"/> Address Change	<input type="checkbox"/> Other _____																
	<input type="checkbox"/> Late Applicant	<input type="checkbox"/> Reduce Coverage	<input type="checkbox"/> Name Change																	
		<input type="checkbox"/> Terminate Coverage																		
	Group Name State of Nevada Public Employees' Benefits Program		Group Number 642682	Division ID Retiree	Retiree Type <input type="checkbox"/> State <input type="checkbox"/> Non-State															
Your Name (Last, First, Middle)		If name change, what was your former name?																		
Your Mailing Address																				
City		State	Zip	Home Phone																
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Retirement	Soc. Sec. No.																	
COVERAGE SECTION	ARE YOU ENROLLED IN THE STATE OF NEVADA PEBP SPONSORED MEDICAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If you answered YES and you are not a reinstated retiree or a survivor, then PEBP provides you with \$10,000 of Basic Life and Accidental Death and Dismemberment (AD&D) coverage. You may elect additional life insurance for yourself by indicating below: VOLUNTARY LIFE INSURANCE <input type="checkbox"/> Retiree (Multiples of \$5,000 to \$50,000 with a minimum of \$10,000) \$ _____ + _____ = _____ Current Amount with The Standard Additional Amount Requested Total Amount Requested																			
	SIGNATURE	I wish to apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. I authorize deductions from my PERS retirement benefit check to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.																		
Retiree Signature Required			Date (Mo/Day/Yr)																	
INSTRUCTIONS	Please return completed form in the enclosed self-addressed envelope: State of Nevada Life Insurance Team Mestmaker Insurance Services P.O. Box 2302 Bakersfield, CA 93303-2302																			

Please retain a copy for your records.