Standard Insurance Company
888.288.1270 Tel

Voluntary Life and Short Term Disability Enrollment and Change Form For Active Employees

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

MEMBER INFORMATION

Enrollment
☐ Initial Enrollment
☐ Late Applicant
☐ Rehire/Reinstatement

Change
☐ Increase Coverage ☐ Add Dependent ☐ Address Change ☐ Name Change
☐ Terminate Coverage ☐ Delete Dependent ☐ Date add/delete ________
☐ Reduce Coverage ☐ Other ________

Group Name	Group Number Pay Center/Agency Name
State of Nevada Public Employees' Benefits Program	642682
Agency Name	Agency Type ☐ State ☐ 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 ☐ Male ☐ Female	Date of Hire	Soc. Sec. No.

VOLUNTARY STD

ARE YOU ENROLLED IN THE STATE OF NEVADA PEBP SPONSORED MEDICAL PLAN? ☐ **YES** ☐ **NO**

Check with your Human Resources Department about eligibility, dependent eligibility, and Evidence of Insurability requirements.

VOLUNTARY SHORT TERM DISABILITY

☐ **Option A** (7-day Benefit Waiting Period) ☐ **Option B** (14-day Benefit Waiting Period) ☐ **Option C** (30-day Benefit Waiting Period)

Annual Salary $ ________ Are you currently enrolled in a Short Term Disability program? ☐ YES ☐ NO

Please see employee booklet for more details.

VOLUNTARY LIFE

If you are enrolled in the State of Nevada PEBP Sponsored Medical Plan, then PEBP provides you with $20,000 of Basic Life and Accidental Death and Dismemberment (AD&D) coverage. You may elect Additional Life insurance for yourself and dependents by indicating below:

VOLUNTARY LIFE AND AD&D INSURANCE

☐ **Employee** *(Multiples of $20,000 to $500,000)*

$ ________ + ________ = ________
Current Amount with The Standard / Additional Amount Requested / Total Amount Requested

DEPENDENTS VOLUNTARY LIFE INSURANCE

☐ **Spouse** *(Multiples of $10,000 to $250,000, not to exceed 100% of your combined Basic and Voluntary Life coverage)*

$ ________ + ________ = ________
Current Amount with The Standard / Additional Amount Requested / Total Amount Requested

Spouse Date of Birth ________

☐ **Dependent Children Voluntary Life** *(Please select one)*

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

SIGNATURE

I wish to apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. I authorize deductions from my wages 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.

Member 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.