PUBLIC EMPLOYEE VOLUNTARY TERM LIFE INSURANCE PLAN Western Insurance Specialties [www.wisnv.com](http://www.wisnv.com/) 800-342-0707

POLICY CONTINUATION FORM Last Name First Name

Number & Street Address Date of Birth

|  |  |  |
| --- | --- | --- |
| City |  | Social Security Number |
| State | Zip Code | Daytime Phone |
| Email Address |  | After Hours Phone |

***Child and Accidental Death coverage automatically stays in place at the previous rates effective 03-01-2018.***

Please indicate below your smoking status Monthly rate per $10,000 of Coverage

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Member | Spouse |  | | |
| Non-smoker | Non-smoker | Age | Non-Smoker | Smoker |
|  |  | <30 | $1.61 | $2.14 |
| Smoker | Smoker | 30-34 | $1.80 | $2.39 |
|  |  | 35-39 | $2.36 | $3.15 |
|  |  | 40-44 | $3.31 | $4.41 |
|  |  | 45-49 | $5.58 | $7.43 |
|  |  | 50-54 | $8.79 | $11.72 |
|  |  | 55-59 | $13.70 | $18.27 |
|  |  | 60-64 | $18.62 | $24.82 |
|  |  | 65-69 | $31.19 | $41.58 |
|  |  | 70-74 | $51.60 | $68.80 |
|  |  | 75+ | $129.47 | $172.62 |

If you with to reduce your current level of Life Insurance please indicated on the lines below.

$ $

Member Amount Spouse Amount

I wish to continue in the program at my same levels. I do not wish to continue in the program.

Members Signature Spouse's Signature

Date: Date:

Return form to: Western Insurance Specialties, P.O. Box 12910, Reno, NV 89510

**THIS IS TO NOTIFY THE PUBLIC EMPLOYEES RETIREMENT SYSTEM OF**

**NEVADA THAT I, , AM RETIRING FROM**

Please print name

**\_, AND MY LAST SCHEDULED PAY CHECK**

Employer

**WILL BE ON . I AUTHORIZE THE DEDUCTION OF MY VOLUNTARY SUPPLEMENTAL LIFE INSURANCE PREMIUMS FROM MY RETIREMENT CHECK. I FURTHER STATE THAT THESE PREMIUMS ARE TO BE PAID OUT ONLY TO *WESTERN INSURANCE SPECIALTIES,***

***INC.* FOR SUBMISSION TO THE INSURANCE CARRIER. FURTHER, I AUTHORIZE *WESTERN INSURANCE SPECIALTIES* TO REQUEST MY MAILING ADDRESS FROM THE PUBLIC EMPLOYEE RETIREMENT SYSTEM**

**FROM TIME TO TIME AS BECOMES NECESSARY.**

Signature Date

Social Security Number

Address City, State Zip

***CC: WESTERN INSURANCE SPECIALTIES, INC.***

***P.O. BOX 12910***

***RENO, NEVADA 89510***

PUBLIC EMPLOYEE VOLUNTARY LIFE PLAN ELECTRONIC PAYMENT AUTHORIZATION FORM

CONTACT INFORMATION

Name: Address: City:

State, Zip:

Email: Phone: Fax:

PREMIUM PAYMENT

The monthly cost depends upon your age and smoking status, your spouse’s age and smoking status, and the amount of insurance you have selected. Your monthly cost will increase on March 1st after your age reaches the next age bracket. Monthly premium rates are outlined below.

**Rates per $10,000 of coverage** FOR COMPANY USE ONLY Age Non-Smkr Smkr

<30 $ 1.61 $ 2.14 Routing Number (9 digits)

30-34 1.8 2.39 Account Number

35-39 2.36 3.15 Voided Check Number

40-44 3.31 4.41

45-49 5.58 7.43

50-54 8.79 11.72

55-59 13.70 18.27

60-64

65-69

70-74

18.62

31.19

51.60

24.82

41.58

68.80

75+ 129.47 172.62

Initial Monthly Payment Amount: $

Method of Payment: Checking

Frequency of Payments: Monthly

Start Date: **5th 10**th **15th 20th**

***ATTACHED VOIDED CHECK HERE***

PAYMENT AUTHORIZATION

I authorize Western Insurance Specialties, Inc. (Company) to debit my account as identified above according to the terms stated herein. This authorization shall remain in effect until Company receives written notification from my intent to terminate this payment plan and at such time and in such manner as to afford Company reasonable opportunity to act (minimum of thirty (30) days).

I authorize this plan to continue, including age change advancements pursuant to the schedule listed above, unless the plan is terminated by me.

**I understand that this payment plan is 100% Non Refundable.**

All other changes such as payment frequency and bank account numbers will require a new Electronic Payment Authorization Form be filled out and submitted to Company fifteen (15) days prior to said change being implemented. I understand that this payment plan may be cancelled by Company or NetDeposit LLC, due to Non-Sufficient Funds (NSF). I understand that I will be liable to pay any NSF fees that may be charged by my bank.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this electronic payment plan. I indemnify and hold Company (the originator), the bank (the ODFI), and NetDeposit, LLC (the software provider) harmless from damage, loss or claim resulting from all authorized actions hereunder.

Customer’s Signature Date

CHANGE REQUEST FORM

Public Employee Voluntary Life Insurance Policy

**Name of Employee:**

**Employee’s Social Security Number (SSN):**

**Employee's Current Address:**

**Employee’s Current Phone Number:**

***Primary Beneficiary(ies)***

**Name Date of Birth SSN Phone Address Relationship**

**% in whole**

**# to equal**

**100**

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***Contingent Beneficiary(ies)***

**Name Date of Birth SSN Phone**

**Address**

**Relationship**

**% in whole**

**# to equal**

**100**

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***Cancel Coverage: Reduce Coverage to:***

Employee Coverage Employee Coverage

please initial Coverage Amount Desired

Spouse Coverage Spouse Coverage

please initial Coverage Amount Desired

Dependent Child Dependent Child Coverage

please initial Coverage Amount Desired

AD&D Coverage AD&D Coverage

please initial Coverage Amount Desired

***Name Change to: Address Change:***

**SIGNATURE: Date:**

**Mail to: Western Insurance Specialties**

**P.O. Box 12910**

**Reno, NV 89510: For Questions Call 775-826-2333 opt 1**

**Fax # 775-826-2390: Email:** [**service@wisnv.com**](mailto:service@wisnv.com)