



CHANGE OF MEMBER CONTRIBUTION PLAN

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This form should be completed if member is changing from the employee/employer contribution plan to the employer-pay contribution plan within the agency or from police/fire to a regular position or from a regular position to a police/fire position within the same agency.

Member Information

Social Security Number: _____

Member's Name: _____
First MI Last

Position Change Information

- Change from Police/Fire Position Effective Date: ____/____/____
 Change to Police/Fire Position Effective Date: ____/____/____

New Position Title: _____

Change to Employer-Pay Contribution Plan

(Members' signature is required for this section)

Initial Employer-Pay Plan Effective Date: ____/____/____

With my signature I certify that I understand that once I choose the employer-pay contribution plan, I cannot change back to the employee/employer contribution plan.

Member's Signature: _____

Agency Certification

(This form must be signed by the Liaison Officer or an Authorized Rep. in order to be processed)

Signature: _____ Date: ____/____/____
Liaison Officer or Authorized Representative

Agency Name

Agency #