



Las Vegas Police Protective Association Metro, Inc.

MEMBERSHIP APPLICATION FORM FOR COMMISSIONED METRO/CITY EMPLOYEES

P # _____

FIRST NAME: _____ LAST NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____

EMERGENCY CONTACT - NAME: _____ PHONE: _____

DATE OF BIRTH: _____ DATE OF HIRE: _____ MALE _____ FEMALE _____

SS#: _____ - _____ - _____ PERSONAL EMAIL(not LVMPD): _____

METRO EMPLOYEE: _____ CITY EMPLOYEE: _____

BUREAU: _____ CLASSIFICATION: _____

SIGNATURE: _____ DATE: _____

- DONATIONS TO LAW ENFORCEMENT ASSISTANCE FUND (L.E.A.F.) ARE DEDUCTIBLE AS A CHARITABLE CONTRIBUTION.
- PPA DUES WILL NOT BE DEDUCTED FROM YOUR CHECK UNTIL YOU GRADUATE FROM THE ACADEMY. THE ATTACHED PAYROLL DEDUCTION SHEET MUST BE SIGNED AND DATED BY YOU AND ATTACHED TO THIS FORM
- YOU MAY TERMINATE YOUR DUES DEDUCTIONS DURING THE DROP PERIOD SET FORTH IN THE COLLECTIVE BARGAINING AGREEMENT. PRESENTLY, THE DROP PERIOD IS OCTOBER 1ST - 20TH EACH YEAR.

Updated February 2023

9330 W. Lake Mead Blvd., #200 - Las Vegas - Nevada - 89134
Phone: (702) 384-8692 - Fax: (702) 384-7989
Email: office@lvppa.com - Website: www.lvppa.com

**LAS VEGAS METROPOLITAN POLICE DEPARTMENT
PAYROLL RECURRING DEDUCTION SHEET**

Employee Name	P#	Daytime Contact Number
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Wage Type	Deduction Type	Deduction Amount	Start Date	Stop Date	
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DUES

5009	Black Police Dues (24 pay periods)				
5010	NLPOA Dues (24 pay periods)				
5007	PMSA Dues (24 pay periods)				
5005	PPA Dues (24 pay periods)	39.00	ASAP		
5006	PPACE Dues (all pay periods)				
5008	SPA Dues (24 pay periods)				

MISCELLANEOUS DEDUCTIONS

5200	Law Enforcement Assist Fund - LEAF (24 pay periods)				<input type="checkbox"/> One Time <input type="checkbox"/> Recurring
5435	PMSA Foundation (24 pay periods)				<input type="checkbox"/> One Time <input type="checkbox"/> Recurring
5403	Police Museum (24 pay periods)				<input type="checkbox"/> One Time <input type="checkbox"/> Recurring
5404	Prepaid Legal Svcs. (24 pay periods)				
5400	United Way (26 pay periods)				<input type="checkbox"/> One Time <input type="checkbox"/> Recurring
	Other				

LOANS

					Declining Balance
5411	Employee Reimbursement		Reason:		
5223	BPA Loan (all pay periods)				
5220	PPACE Assoc. Loan (all pay periods)				
5210	SPA Loan (24 pay periods)				
5410	Purchase Retirement (24 pay periods)	<i>To purchase retirement you must initiate your request through PERS. You may stop the deduction using this form.</i>			
5413	Purchase Retirement 2 (24 pay periods)				

Employee Signature & PN <small>(Sign name as it appears on paycheck)</small>	Date	Representative Signature	Date
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To Be Completed By Las Vegas PP Association

Group Number 649305	Division	Billing Category	Date of Membership
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To Be Completed By Applicant Apply for Coverage Beneficiary Change *Complete Beneficiary Section below.* Name Change
 Add or Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Address		City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>			Phone Number	
Employer Name Las Vegas Police Protective Association			Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

Coverage Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.

Life Insurance

- Noncontributory Life and AD&D (paid by the Association)
- Contributory Life Your requested amount \$ _____
- Contributory AD&D Your requested amount \$ _____

Dependents Life Insurance

- Spouse Life Requested amount \$ _____
 Spouse Name _____ Date of Birth _____
- Child(ren) Life Requested amount \$ _____

Beneficiary *This designation applies to Noncontributory Life and AD&D Insurance.*

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Beneficiary *This designation applies to Contributory Life and AD&D Insurance only available through your Employer.*

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Signature I wish to make the choices indicated on this form. If electing coverage, 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. Designations above are not valid unless signed, dated and delivered to the Association during your lifetime.

Member/Employee Signature Required _____ **Date (Mo/Day/Yr)** _____