____ New Employee

____ Retiree

____ Surviving Spouse / Dependent

CLARK COUNTY, NEVADA AND AFFILIATES
BENEFITS ENROLLMENT FORM

____ Qualified Life Event (QLE)

____ Open Enrollment Change

ENTITY:

EFFECTIVE DATE: _____

_____ Clark County		
_____ District Court	_____ Las Vegas Valley Water District	_____ RTC
_____ Henderson Library	_____ Mt. Charleston Fire	_____ So. Nev. Health District
_____ LVMPD -Appointed	_____ Moapa Valley Fire District	_____ University Medical Center
_____ Las Vegas Convention & Visitor's Authority	_____ Regional Flood	_____ Water Reclamation District

PARTICIPANT INFORMATION

NAME, LAST FIRST M.I.	PERSONAL IDENTIFICATION NO.	BIRTH DATE	SEX ❏ FEMALE ❏ MALE
MAILING ADDRESS		HOME PHONE	
CITY STATE ZIP		WORK PHONE	
DEPARTMENT HIRE DATE		CELL PHONE	

PERSONAL E-MAIL ADDRESS: _____   **WORK E-MAIL ADDRESS**: _____

HEALTH PLAN CHOICES

❏ Clark County Self-Funded Group Medical and Dental Benefits Plan (PPO)

❏ Clark County Exclusive Provider Organization (EPO)

❏ I Decline / Waive All Coverage for Myself and My Dependents –   Reason: _____

❏ I Decline/Waive Dental and/or Vision ___ Coverage for Myself and My Dependents   Reason: _____

I choose coverage for: ❏ Participant Only   ❏ Participant *plus* Spouse   ❏ Participant *plus* Child(ren)   ❏ Participant *plus* Family Spouse & Child(ren)

FAMILY INFORMATION: Use additional page if needed, be sure to sign and date. Please list all eligible family members to be enrolled. A copy of your marriage certificate and social security card are required when adding a spouse. A copy of your child(ren)'s birth certificate(s) and social security card(s) are a requirement when electing coverage for child(ren).

NAME	SEX	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER

Basic life insurance is automatically provided to each eligible employee or retiree. When a retiree reaches age 70 the amount of coverage decreases. Dependents covered under the medical coverage are also covered under the basic life insurance in lesser amounts. Employees may also apply for supplemental life insurance coverage. **Participation in the supplemental life program requires a completion of a separate enrollment form.**

Basic Life Insurance Beneficiary Designation

Primary Beneficiary	**Contingent Beneficiary**
Name _____	Name _____
Mailing Address _____ _____	Mailing Address _____ _____
Relationship _____	Relationship _____

PARTICIPANT CERTIFICATION

I certify under penalty of perjury that the above answers are true to the best of my knowledge. I am aware if I elect not to enroll myself or my eligible dependents at the time of initial eligibility that I may only enroll or add dependents as allowed under the terms and conditions of the Clark County employer sponsored health plans. I understand that benefits will be available subject to the exclusions, limitations and benefits described in the Clark County employer sponsored health plans. I acknowledge that I must notify my employer within 31 days of any change in dependent eligibility. **I hereby acknowledge and agree that all health insurance premiums will be deducted on a pre-tax basis from my earnings for the coverage elected and that this election will remain in effect for the rest of the plan year unless I experience a Qualifying Event as defined.**

❏ **I choose to have my contribution deducted on a post-tax basis**

Signature: _____   **Date:** _____

Risk Management Use
Coverage
Effective
Date: _____
Initials: _____