Risk Management

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GUARANTOR AFFIDAVIT FORM
CLARK COUNTY DEPENDENT VERIFICATION INQUIRY

Employee Personnel Number:__________________________Employee Name:____

Employee Phone Number ____

Employer:_________________________________Spouse/Dependent Name(s):____

☐ **Clark County Self-Funded PPO (CCSF)** covers an eligible spouse and dependents ages 0-26. Coverage determination is based upon the spouse and/or dependent(s) permanent residency outside the State of Nevada. Once eligibility has been approved the spouse and/or dependent(s) are assigned to their geographical United Healthcare Choice Plus PPO Network. Provider listing can be found at the Risk Management site under www.clarkcountynv.gov *Dependents must live outside the State of Nevada*.

Dependent(s) Address:______________________________________City/State/Zip________________________________

☐ Use policyholder mailing address.
☐ Dependent has moved back into local PPO area as of _________________

☐ **Clark County EPO** requires the eligible dependent(s) ages 17-26 to be a full-time student in either an accredited university, college, or trade school to be assigned to the United Healthcare National Network (PPO). Once eligibility has been approved the dependent(s) will be assigned to their geographical United Healthcare National Choice Plus PPO Network. Provider listing can be found at the Risk Management site under www.clarkcountynv.gov *Dependents must live outside the State of Nevada*.

College/Trade School: ____

School Address: ____

Dependent(s) Address: ____

☐ Use policyholder mailing address.
☐ Dependent has moved back into local PPO area or no longer meets full-time student status as of_______________________

The effective date of the geographical assignment for both Clark County Self-Funded PPO and Clark County EPO will be effective the first of the month following Clark County Risk Management's receipt of this affidavit.

I certify and affirm that the eligible dependent(s) listed above meets the stated requirements and that the information provided is true and complete. Any changes must be reported to Clark County Risk Management.

I attest under penalty of perjury that this information is true as of the date of my signature hereon and I further acknowledge that I must notify my employer within 31 days of any change in residency status.
I understand and acknowledge that in the event this information is untrue or inaccurate or I fail to remove my dependent(s) within 31 days from the date the dependent(s) no longer meets these requirements, then this could be considered fraudulent and may subject me to a variety of consequences including but not limited to, referral to Clark County's District Attorney's Office for criminal prosecution, restitution to the Plan for improperly paid medical/dental/pharmacy claims and premiums, referral to my employer for disciplinary action up to and including termination of employment and termination of my health coverage.

Employee Signature:____Date: _________________________

Completed form can be e-mailed to Benefits@umcsn.com or faxed to 702-383-2005