2025 OPEN ENROLLMENT

CLARK COUNTY HEALTH BENEFIT CHANGE FORM

PLEASE CHECK ONE:

__ Clark County	__ Las Vegas Valley Water District	__ Retiree
__ COBRA Participant	__ Mt. Charleston Fire Dept.	__ S. NV Health District
__ Henderson Library	__ Moapa Valley Fire District	✔ University Medical Center
__ Las Vegas Convention & Visitors Authority	__ Regional Flood Control District	__ Water Reclamation District

PERSONAL IDENTIFICATION NUMBER _____ EFFECTIVE DATE 12/31/2024

LAST NAME _____ FIRST NAME _____ M.I _____

WORK PHONE NO. _____ CELL PHONE NO. _____ WORK E-MAIL _____

__ **NAME CHANGE FOR EMPLOYEE** __ **NAME CHANGE FOR DEPENDENT** __ **ADDRESS CHANGE**

NEW NAME : _____ (LAST NAME) _____ (FIRST NAME) _____ (M.I)

NEW ADDRESS: _____ (STREET)

CITY/STATE/ZIP CODE: _____ TELEPHONE NO. _____

__ **ADDING DEPENDENTS** ✔ **DELETING DEPENDENTS**

	LAST NAME	FIRST NAME	M.I	SOCIAL SECURITY NUMBER	D.O.B.	SEX M F
SPOUSE						
CHILD						
CHILD						
CHILD						
CHILD						

EXPLANATION
(APPROPRIATE BOX MUST BE MARKED, AND LEGAL DOCUMENTATION ATTACHED)

__ Marriage, date _____
__ Birth or adoption of child, date _____
__ Divorce, date _____
__ Death of spouse or dependent, date _____
__ Switching from part-time to full-time (or vice-versa) employment on the part of me or my spouse, date _____
My spouse or I have taken unpaid leave of absence, date _____
__ Re-enrollment
__ Involuntary loss of other health insurance coverage, date _____
✔ Other OPEN ENROLLMENT

_____
_____

Basic Life Insurance Beneficiary Designation - Complete only if you wish to make changes

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

I certify under penalty of perjury that the above information is true to the best of my knowledge. I understand that benefits will be available subject to the exclusions, limitations, and benefits described in the Clark County Group Medical and Dental Benefit Plan(s). I hereby authorize my employer to modify my payroll deduction from my earnings as required due to the above requested change.

_____ DATE

_____ EMPLOYEE'S SIGNATURE

Risk Mgmt Use
Entry Date _____
Initials _____