

____ New Employee
____ Retiree
____ Surviving Spouse/Dependent

CLARK COUNTY, NEVADA AND AFFILIATES
BENEFITS ENROLLMENT FORM

____ Qualified Life Event (QLE)
____ **X** Open Enrollment Change

CC EPO _____ **CCSF PPO** _____ **EFFECTIVE DATE:** **01/01/2026**

ENTITY:

****2026 - OPEN ENROLLMENT****

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

P A R T I C I P A N T	NAME, LAST _____ FIRST _____ M.I. _____	PERSONAL IDENTIFICATION NO. _____	BIRTH DATE _____	SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> 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 - Complete only if you wish to make changes

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: _____
