Office of the County Manager
Office of Risk Management

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Les Lee Shell, Chief Administrative Officer

COMPLETE AND ATTACH TO YOUR ENROLLMENT FORM IF YOU SELECT THE CLARK COUNTY SELF- FUNDED GROUP MEDICAL AND DENTAL BENEFITS PLAN AND YOU ARE ENROLLING A SPOUSE

CLARK COUNTY SPOUSAL INSURANCE INQUIRY LETTER

Employee Personnel Number: _____ Employee Name: _____

Effective 1/1/2004, the Clark County Self-Funded Group Medical and Dental Benefits Plan (CCSF) requires dependent spouses when covered under CCSF, to enroll in their own employer-sponsored program, if available.

Clark County Self-Funded Group Medical and Dental Benefits Plan Document
Dependent Eligibility pg. 8: states:
R**equirement for spousal enrollment in other group insurance**. If a spouse is covered as a dependent of an employee or retiree covered by CCSF and the spouse is employed by a company that offers an employee health benefit plan (Medical/Dental), or a retiree benefit plan as a retiree of another company, and he/she is eligible for such coverage at a monthly cost of $100.00 or less for employee only, the spouse is required to enroll in such other employer-sponsored program. If the spouse declines such other employer-sponsored coverage, CCSF will provide coverage to the spouse at 20% of the Plan allowable, instead of the normal benefit payable for such services covered by CCSF. When the penalty is imposed, there will be no prescription coverage as CCSF does not coordinate benefits.

Please fill out this questionnaire completely and return to your employer's benefits representative.

1. Spouse's Name: _____
2. Is your spouse offered health insurance coverage? Yes ____ No ____
3. Insurance monthly premium (medical + dental) $_____
4. Insurance rate sheet attached Yes ____ No ____
5. Name of employer _____
6. Employer address _____
7. Employer telephone number (____)_____
8. Insurance plan information:
   - Effective date of coverage: _____ Policy number: _____
   - Name of insurance company: _____
   - Address of insurance company: _____
9. Was employer sponsored coverage elected? Yes ____ No ____

I certify and affirm that my spouse listed above is an eligible dependent pursuant to the provisions and requirements as outlined in the Clark County Self-Funded Group Medical and Dental Benefits Plan as revised 08-18, pages 6-8 Eligibility Provisions – Dependent Eligibility. I further certify that my spouse is not offered an employer sponsored health plan insurance or a retiree benefit plan for $100 dollars a month or less.
I attest under penalty of perjury this information is true to the best of my knowledge as of the date of my signature hereon and I further acknowledge that I must notify my employer **within 31days** of any change in this eligibility.

I understand and acknowledge that in the event such information is untrue or inaccurate or I fail to remove a dependent from my chosen health plan within 31 days from the date that they longer qualify as a dependent pursuant to the provisions and requirements of coverage, then this fraud may subject me to a variety of consequences including but not limited to, referral to the District Attorney's Office for criminal prosecution, restitution to the Plan for improperly medical/dental/pharmacy paid claims and premiums, referral to my employer for disciplinary action up to and including termination, and termination of my health coverage.

Employee Signature: _____ Date: _____

Completed form can be emailed to: CCSelfFundedOpenEnrollment@ClarkCountyNV.Gov or faxed to: (702) 455-3084