Office of the County Manager
Office of Risk Management

500 S Grand Central Pky 1st Fl • Box 551711 • Las Vegas NV 89155-1711
(702) 455-4544 • Fax (702) 455-3084

Les Lee Shell, Chief Administrative Officer

GUARANTOR AFFIDAVIDT FORM

CLARK COUNTY DEPENDENT VERIFICATION INQUIRY

Employee Personnel Number: _____Employee Name: _____

Employer: _____ **Dependent Name(s):**_____

Insurance Plan (circle one) CCSF HPN

Clark County Self-Funded Group Medical and Dental Benefits Plan (CCSF) covers eligible dependents ages 0-26. Aetna's Signature Administrators PPO determination is based upon the dependent(s) permanent residency outside the State of Nevada. Once eligibility has been approved the dependent(s) are assigned to their geographical Aetna Signature Administrators PPO Network.

CCSF Dependent(s) Address: _____
City/State/Zip: _____

Health Plan of Nevada (HPN) **requires** the eligible dependent(s) ages 17-26 to be a full time student in either an accredited university, college or trade school in order 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 PPO Network.

HPN Student Status (circle one) Full Time Part Time College/Trade School : _____
Address: _____
City/State/Zip: _____

Does your CCSF or HPN dependent/student have insurance coverage through another carrier? (circle one) Yes No
If yes, please provide the insurance information below.

Other insurance plan information:

Name of Insured: _____
Effective date of coverage: _____ Policy number: _____
Name of insurance company: _____
Address of insurance company: _____

The effective date of the geographical assignment for both CCSF and HPN will be effective the first of the month following Clark County Risk Management's receipt of this affidavidt.

I certify and affirm that the eligible dependent(s) listed above meets the stated requirements and that the information provided is true and complete.
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 31days** 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 emailed to: CCSelfFundedOpenEnrollment@ClarkCountyNV.Gov or faxed to: (702) 455-3084