____ New Employee
____ Retiree
____ Surviving Spouse / Dependent

CLARK COUNTY, NEVADA AND AFFILIATES BENEFITS ENROLLMENT FORM

___ Qualified Life Event (QLE)
___ Open Enrollment Change

CC EPO _____ CCSF PPO_____ EFFECTIVE DATE: _____

ENTITY:

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

PARTICIPANT INFORMATION

NAME, LAST	FIRST	M.I.	PERSONAL IDENTIFICATION NO.	BIRTH DATE	SEX ❑ FEMALE ❑ 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

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: _____

RETURN COMPLETED FORM TO RISK MANAGEMENT

REV. 09-6-2021