2024 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

_____ 01/01/2024

PERSONAL IDENTIFICATION NUMBER — EFFECTIVE DATE

_____ _____ _____

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 _____