

New Employee  
 Retiree  
 Surviving Spouse/Dependent

## CLARK COUNTY, NEVADA AND AFFILIATES BENEFITS ENROLLMENT FORM

Qualified Life Event (QLE)  
 Open Enrollment Change

**CCSF PPO** \_\_\_\_\_ **CC EPO** \_\_\_\_\_

**For HR Use**  
**EFFECTIVE DATE:** \_\_\_\_\_

**ENTITY:**

<input type="checkbox"/> Clark County	<input type="checkbox"/> Las Vegas Valley Water District	<input type="checkbox"/> RTC <b>**2024**</b>
<input type="checkbox"/> Henderson Library	<input type="checkbox"/> Mt. Charleston Fire	<input type="checkbox"/> So. Nev. Health District
<input type="checkbox"/> LVMPD -Appointed	<input type="checkbox"/> Moapa Valley Fire District	<input checked="" type="checkbox"/> University Medical Center
<input type="checkbox"/> Las Vegas Convention & Visitor's Authority	<input type="checkbox"/> Regional Flood	<input type="checkbox"/> Water Reclamation District

<b>P I R T I C I P A N T</b>	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)  
 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:** \_\_\_\_\_

<b>Risk Management Use</b> Coverage Effective Date: _____ Date: _____ Initials: _____
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