____ New Employee
____ Retiree
____ Surviving Spouse / Dependent

CLARK COUNTY, NEVADA AND AFFILIATES
BENEFITS ENROLLMENT FORM

___ Qualified Life Event (QLE)
_X_ Open Enrollment Change

CC EPO ______ **CCSF PPO** ______ **EFFECTIVE DATE:** 01/01/2025

2025 - OPEN ENROLLMENT

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
____X____ 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 - Complete only if you wish to make changes

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