

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

PERSONAL IDENTIFICATION NUMBER **EFFECTIVE DATE** 12/31/2026

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 _____