

\_\_\_\_ Employee  
 \_\_\_\_ Retiree  
 \_\_\_\_ COBRA Participant  
 \_\_\_\_ Surviving Spouse/Dependent

**CLARK COUNTY, NEVADA AND AFFILIATES  
 BENEFITS ENROLLMENT FORM**

\_\_\_\_ New Hire  
 \_\_\_\_ Open Enrollment  
 \_\_\_\_ Change

**EFFECTIVE DATE:** \_\_\_\_\_

**ENTITY:**

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

<b>P I R T I C I P A N T I O N</b>	NAME, LAST	FIRST	M.I.	PERSONAL IDENTIFICATION NO.	BIRTH DATE	SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
	MAILING ADDRESS				HOME PHONE	OTHER INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME OF PLAN:
	CITY	STATE		ZIP	WORK PHONE	
	DEPARTMENT				HIRE DATE	

**E-MAIL ADDRESS:** \_\_\_\_\_ **CELL PHONE:** \_\_\_\_\_

**HEALTH PLAN CHOICES**

Clark County Self-Funded Group Medical and Dental Benefits Plan

Health Plan of Nevada (HMO)

I Decline/Waive All Coverage for Myself and My Dependents – Reason: \_\_\_\_\_

I Decline/Waive Dental Coverage for Myself and My Dependents – Reason: \_\_\_\_\_

I Decline/Waive Vision Coverage for Myself and My Dependents – Reason: \_\_\_\_\_

I choose coverage for:  Participant Only  Participant *plus* Spouse/  
 Domestic Partner  Participant *plus* Child(ren)  Participant *plus* Family  
 Spouse/Domestic Partner & 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/Domestic Partner Registration and social security card are required when adding a spouse/Domestic Partner. 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**

<b>Primary Beneficiary</b>	<b>Contingent Beneficiary</b>
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 authorize my employer to deduct on a pre-tax basis any required contributions from my earnings for the coverage I select.
- I choose to have my contribution deducted on a post-tax basis.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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