CLARK COUNTY HEALTH BENEFIT CHANGE FORM

PLEASE CHECK ONE:

Clark County	Las Vegas Valley Water District	Henderson Library
Retiree	Mt. Charleston Fire Dept.	S. NV Health District
COBRA Participant	Moapa Valley Fire District	University Medical Center
Las Vegas Convention & Visitors Authority	Regional Flood Control District	Water Reclamation District
LVMPD - Appointed	RTC	District Court

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 ____
____

Basic Life Insurance Beneficiary Designation

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 ________