



**WASHOE COUNTY  
BENEFITS ENROLLMENT/CHANGE FORM**

<b>FOR COUNTY USE ONLY:</b>	
SAP#:	_____
Hire Date:	_____
Term Date:	_____
Location:	_____

Effective Date:

PERSONAL INFORMATION			
Name (First, Last and middle initial)		Date of Birth	SSN
Mailing Address <input type="checkbox"/> Check Box If New Address		City	State <span style="margin-left: 20px;">Zip Code</span>
Email Address	Home Phone	Cell Phone	Other Phone
MEDICAL PLAN ELECTION		<input type="checkbox"/> Retiree Only	<input type="checkbox"/> Retiree + Spouse/DP
		<input type="checkbox"/> Retiree + Child(ren)	<input type="checkbox"/> Retiree + Family
<b>Medicare Election (self):</b> Part A <input type="checkbox"/> Effective Date: _____ Part B <input type="checkbox"/> Effective Date: _____ Not Eligible: <input type="checkbox"/> If applicable, provide a copy of Medicare Card.		<b>Medicare Election (spouse):</b> Part A <input type="checkbox"/> Effective Date: _____ Part B <input type="checkbox"/> Effective Date: _____ Not Eligible: <input type="checkbox"/> If applicable, provide a copy of Medicare Card.	
<input type="checkbox"/> PPO Plan		<input type="checkbox"/> High Deductible Health Plan	
<input type="checkbox"/> Surest Plan		<input type="checkbox"/> Medicare Advantage Plan	
<b>DENTAL INSURANCE (optional)</b>		<input type="checkbox"/> I am Electing Dental Coverage	<input type="checkbox"/> I am Not Electing Dental Coverage
ELIGIBLE DEPENDENT INFORMATION: List ALL person(s) to be covered			
Spouse/Domestic Partner:			
First Name, MI, Last Name		Date of Birth	SSN (required)
Child:			
First Name, MI, Last Name		Date of Birth	SSN (required)
Child:			
First Name, MI, Last Name		Date of Birth	SSN (required)
Child:			
First Name, MI, Last Name		Date of Birth	SSN (required)
Child:			
First Name, MI, Last Name		Date of Birth	SSN (required)

## LIFE INSURANCE BENEFICIARY DESIGNATION

Check Box If New Beneficiary

### PRIMARY BENEFICIARY(IES) Address and phone number required

Name:		
Address:		Phone:
Relationship:	Date of Birth:	Benefit Percent:
Name:		
Address:		Phone:
Relationship:	Date of Birth:	Benefit Percent:
Name:		
Address:		Phone:
Relationship:	Date of Birth:	Benefit Percent:
Name:		
Address:		Phone:
Relationship:	Date of Birth:	Benefit Percent:

### CONTINGENT BENEFICIARY(IES) Address and phone number required

Name:		
Address:		Phone:
Relationship:	Date of Birth:	Benefit Percent:
Name:		
Address:		Phone:
Relationship:	Date of Birth:	Benefit Percent:
Name:		
Address:		Phone:
Relationship:	Date of Birth:	Benefit Percent:
Name:		
Address:		Phone:
Relationship:	Date of Birth:	Benefit Percent:

### Retiree Authorization and Signature (Required)

I hereby elect the benefit plan(s) designated on this form. I have also listed my eligible dependent(s) to be added to, or deleted from, the designated benefit plan(s).

By signing this form, I agree for myself and on behalf of my covered dependents to abide by the rules and regulations of my chosen health plan and authorize any hospital, physician or other licensed health care provider to disclose any/or all information with respect to any illness, injury or medical history regarding me or any of my dependents to the claims administrator/HMO or utilization review/case management company, or their agents, upon their request. A copy of this authorization shall be considered as effective and valid as the original.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_