WASHOE COUNTY
BENEFITS ENROLLMENT/CHANGE FORM

FOR COUNTY USE ONLY:

SAP#: _____
Hire Date: _____
Term Date: _____
Location: _____

Effective Date:

PERSONAL INFORMATION

Name *(First, Last and middle initial)*		Date of Birth	SSN	
Mailing Address ☐ Check Box If New Address		City	State	Zip Code
Email Address	Home Phone	Cell Phone	Other Phone	

MEDICAL PLAN ELECTION

☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child(ren) ☐ Retiree + Family

Medicare Election (self):	Medicare Election (spouse):
Part A ☐ Effective Date:	Part A ☐ Effective Date:
Part B ☐ Effective Date:	Part B ☐ Effective Date:
Not Eligible: ☐ If applicable, provide a copy of Medicare Card.	Not Eligible: ☐ If applicable, provide a copy of Medicare Card.
☐ **PPO Plan**	☐ **High Deductible Health Plan**
☐ **HMO Plan**	☐ **Medicare Advantage Plan**

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 toany 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: