2020 Plan Year
Clark County Employee Benefits
Health Insurance Opt-Out Certification Form

Employee Information:			
Employee's Name (Last, First, MI):		Employee ID or SSN:	Date of Birth:
Dept:	Work Phone:	Date of Hire:	Union/Guild:

Health Care Coverage Information:		
Policy Holder Information (i.e. spouse/domestic partner)		
Name of Policy Holder:	Relationship:	Policy Holder's Birth date:
Policy Holder's Employer:	Employer Contact Name and Phone Number:	

Group Insurance Plan Information For Medical:				
Name of Insurance Provider:	Address:	City:	State:	Zip:
Effective Date your coverage began:	Group No:	Member ID No:		
This Group Insurance Plan covers: □ Medical □ Rx □ Vision				

Group Insurance Plan Information For Dental:				
Name of Insurance Provider:	Address:	City:	State:	Zip:
Effective Date your coverage began:	Group No:	Member ID No:		

Acknowledgement:

I elect to waive coverage under the Clark County medical/vision and/or dental plans (the Plans) for the plan year beginning January 1, 2020 and ending December 31, 2020. I have received a copy of the Health Benefits Summary describing the plans, and understand that I am giving up my right to participate in the Plans and receive the benefits described in the Summary. I understand and acknowledge:

- I am eligible to waive coverage only if I am covered by another **group** health plan. I attest that the information I have provided regarding the other coverage is true and accurate.
- I understand that if I am covered by Medicare or TRICARE or other government sponsored health plan including any Health Insurance Exchange Plan I **will not receive any cash in lieu of coverage as it is not allowed under federal law.**
- I must notify the County's Human Resources-Benefits Department (HR) in writing within 31 calendar days of losing other group coverage or discontinuance of employer contributions for such coverage causing a significant increase in cost or exhaustion of continuation coverage (i.e. COBRA) in order to re-enroll in a County Health Plan. If I do not notify HR within 31 calendar days of losing other coverage, I will not be permitted to re-enroll in the Plans until the next open enrollment with coverage effective January 1, 2021.
- I may revoke this waiver for me or for myself and spouse/domestic partner and children if I notify HR in writing within 31 calendar days of gaining a spouse/domestic partner and dependent child by marriage, birth, adoption or placement for adoption.
- If I re-enroll in the Plans after having waived coverage, I will be subject to the provisions of the Plans in effect when I enroll.
- If an event occurs while this waiver is in effect that would have otherwise permitted me or my spouse or dependents to be offered COBRA continuation coverage, none will be offered or available under the Plan due to this waiver.

_____ _____

Employee Signature Date

Retain a copy for your records