

SUPPORT STAFF HEALTH INSURANCE CHANGE FORM

Participant Name: _____

Office Use Only

Effective Date

Social Security Number: _____

Type of change to be made:

- _____ Name, address and/or phone number (Complete Section A)
- _____ Change of Life Insurance beneficiary (Complete Section B)
- _____ Change of plan coverage (Complete Section C)
- _____ Add or delete coverage for a dependent (Complete Section D)
- _____ Section 125 Premium-Only-Plan (POP) (Complete Section E)

Are you married to a CCSD Employee?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name _____	
Soc. Sec. No. _____	

SECTION A – Name, Address and/or Phone Number

New Name	Current Name on Record	New Phone Number
New Address _____		
City	State	Zip

SECTION B – Change of Life Insurance Beneficiary

New Beneficiary	Relationship
Address _____	
City	State Zip

SECTION C – Change of Plan Coverage

<i>Current Medical Plan</i>	<i>New Medical Plan</i>
HPN – HMO _____	HPN – HMO* _____
HPN/Sierra – POS _____	HPN/Sierra – POS _____
HPN/Sierra – POS+ _____	HPN/Sierra – POS+ _____
NevadaCare – HMO _____	NevadaCare – HMO _____
NevadaCare – POS _____	NevadaCare – POS _____
Summerlin – PPO _____	Summerlin – PPO _____
Waive Medical Only _____	Waive Medical Only _____
Waive Medical/Dental/Vision _____	Waive Medical/Dental/Vision _____

Vision and Dental Coverage is Provided with All Selections (except when waived)

SECTION D – Add or Delete Coverage for Dependent(s)

<input type="checkbox"/> Add	Last Name	First Name	Date of Birth	Sex	Soc. Sec. No.	<input type="checkbox"/> Med/Den/Vis
<input type="checkbox"/> Delete						<input type="checkbox"/> Dental Only
<input type="checkbox"/> Add	Last Name	First Name	Date of Birth	Sex	Soc. Sec. No.	<input type="checkbox"/> Med/Den/Vis
<input type="checkbox"/> Delete						<input type="checkbox"/> Dental Only
<input type="checkbox"/> Add	Last Name	First Name	Date of Birth	Sex	Soc. Sec. No.	<input type="checkbox"/> Med/Den/Vis
<input type="checkbox"/> Delete						<input type="checkbox"/> Dental Only

Section E – Section 125 Premium Only Plan (POP)

<input type="checkbox"/> Enroll me in the Section 125 POP	<input type="checkbox"/> Cancel my enrollment in the Section 125 POP
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*If you enroll in the HPN/Sierra – HMO plan, you must contact HPN to select a Primary Care Physician.

Participant Signature _____

Date _____