9998-500164

CCF-164
5/07

STATE OF NEVADA
PUBLIC EMPLOYEES RETIREMENT SYSTEM
Agency: CLARK COUNTY SCHOOL DISTRICT - Number: 202

NOTICE OF REMOVAL FROM RETIREMENT REPORT

693 W. Nye Lane
Carson City, Nevada 89703-1599

Log #:_____

RESIGNATION/RETIREMENT/LEAVE OF ABSENCE

PLEASE PRINT OR TYPE:

Name: _____ SS#:_____ /_____ /_____

Permanent Mailing Address: _____

City/State/Zip: _____ Phone No.: (____)_____

Department/School:_____ Location No.: _____ Work Phone No.: _____

☐ Licensed ☐ School Police ☐ Support Staff ☐ Unified

Position:_____

(Licensed: subject/assignment; grade; track #) (Unified, Support Staff, Police: position; months; hours)

☐ **RESIGNATION:** effective end of day _____/_____/_____(exact date)

☐ **DISMISSAL:** effective end of day _____/_____/_____(exact date)

☐ **INELIGIBLE:** for membership in PERS _____/_____/_____(exact date)

Reason for the above action: _____

_____

☐ **TERMINATION:** Failure to Complete Probation – effective end of day _____/_____/_____ (exact date)

☐ **RETIREMENT:** effective end of day _____/_____/_____ (exact date)

☐ **DISABILITY RETIREMENT:** effective end of day _____/_____/_____ (exact date)

☐ **DEATH:** _____/_____/_____ (exact date)

REQUEST FOR LEAVE OF ABSENCE:

HR USE ONLY- LEAVE:
____APPROVED DATE_____
_____DENIED DATE_____
BY: _____

Beginning_____/_____/_____ through_____/_____/_____

LEAVE DOCUMENTATION MUST BE ATTACHED. LEAVE CANNOT BE PROCESSED WITHOUT REQUIRED DOCUMENTATION. ALL LEAVES REQUIRE APPROVAL OF HUMAN RESOURCES ADMINISTRATOR.

REASON FOR REQUEST:

☐ EMPLOYEE NECESSITY ☐ MILITARY ☐ MATERNITY

☐ MEDICAL ☐ PROFESSIONAL

☐ MEDICAL - WORKERS COMPENSATION (Occupational Injury) ☐ OTHER (SPECIFY):_____ (Political, Instructional/Consultant, etc.)

Have you participated in a CCSD ARL program: ☐ **Yes** ☐ **No**

_____ _____
Employee's Signature (If signature not provided, explanation by Supervising Administrator) Date Submitted

_____ _____
Supervisor/Principal's Signature (As Applicable) Date Signed

_____ _____
Human Resources Administrator/Liaison Officer's Signature Date Signed

PAY DATA/HR USE ONLY:
Last Day of Paid Compensation: _____/_____/_____ Final Paydate: _____/_____/_____

Original & 1st Copy – Human Resources Administrator (Duplicate to PERS)
2nd Copy – Supervisor/Principal
3rd Copy – Benefits
4th Copy – Employee with disposition of HR

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CCSD CLARK COUNTY SCHOOL DISTRICT

IMPORTANT NOTICE
CONTINUATION COVERAGE ("COBRA")

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, as a former CCSD employee you and your family have the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you, your spouse, and eligible dependents must take the time to read this notice carefully.

As a former employee of the Clark County School District previously covered by an insurance health plan, you have the right to choose this continuation coverage at your expense if you lose your existing group health coverage because of a reduction in your hours of employment which resulted in loss of health coverage or because of the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by an eligible health plan, you have the right to choose continuation coverage at your expense if you lose group health coverage for any of the following reasons:

(1) The death of your spouse;
(2) The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment which resulted in a loss of health coverage;
(3) Divorce or legal separation from your spouse; or
(4) Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by an eligible health plan, he or she has the right to continuation coverage at his/her personal expense if group health coverage is lost for any of the following reasons:

(1) The death of a parent/guardian;
(2) The termination of a parent's/guardian's employment (for reasons other than gross misconduct) or reduction in a parent's/guardian's hours of employment which resulted in a loss of health coverage;
(3) Parent's/Guardian's divorce or legal separation;
(4) A parent/guardian becomes entitled to Medicare; or
(5) The dependent ceases to be a "dependent child" under an eligible health plan.

If there is a choice among types of coverage under an existing health plan, each individual eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect a different coverage from the coverage that the employee elects.

The employee or a family member has the responsibility to inform the respective health plan administrator of a divorce, legal separation, or a child losing dependent status. The Clark County School District has the responsibility to notify the appropriate health trust of the employee's death, termination of employment, reduction in hours, or Medicare eligibility. Notice must given to the health plan administrator within 60 days of the occurrence of the event.

When a health plan is notified that one of these events has occurred, it will, in turn, notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the date you lose coverage or from the date you receive notice of your right to elect continuation coverage (whichever date is later) to inform the health plan that you want continuation coverage. If you do not choose continuation coverage, your group health insurance coverage will end. If you elect continuation coverage, the first payment must be received within 45 days of the date such coverage is elected.

If you choose continuation coverage, the respective health plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified.

The law requires that you be afforded the opportunity to maintain eligible coverage for up to three years unless you lost group health coverage because of an employee's termination of employment or reduction in hours. In that case, the required continuation coverage period is for up to 18 months.

For an employee or family member who is disabled, the continuation coverage period is longer. The disability that extends the continuation coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) and Title XVI (Supplemental Security Income) of the Social Security Act. For the extended continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided within 18 months of the employee's termination or reduction in hours of employment. If the disabled beneficiary is finally determined to be no longer disabled under Titles II or XVI of the Social Security Act, coverage will cease the month that begins more than 30 days after such determination.

If a second qualifying event occurs within 18 months after a termination or reduction in hours, you are eligible for up to a maximum of three years of continuing coverage from the date of the termination or reduction in hours.

The law also provides that your continuation coverage may be terminated for any of the following reasons:

(1) The insurance plan sponsor no longer provides group health coverage to any employees;
(2) The premium for your continuation coverage is not paid by you in a timely manner;
(3) You become an employee covered under another group health plan; however, if the new coverage contains any exclusion or limitation with respect to any pre-existing condition of the beneficiary, then this coverage does not end the continuation coverage period;
(4) You become entitled to Medicare; however, for family members other than the employee, the continuation coverage period begins on the date on which the employee becomes entitled to Medicare (or, if applicable, the date of an earlier qualifying event) and extends for up to a maximum of three years.

If you and/or eligible dependents are currently covered, there is no requirement to show that insurability to choose continuation coverage. However, under the law, you have to pay the required premium for your continuation coverage. COBRA also provides that at the end of the 18-month or 3-year continuation coverage period you must be allowed to enroll in an individual conversion health plan which may otherwise be generally available under the respective health plan.

Questions regarding former employee/dependent/spouse eligibility for COBRA and related continuation coverage must be directed to the appropriate health plan administrator for your respective employee group. COBRA continuation coverage is only available for former employees and eligible dependents who were eligible for group health insurance coverage at the time of their employment and at the time of the qualifying event.