Health Insurance New Enrollment/Waiver Form

In order to accurately process your enrollment and ensure that you receive your insurance card and information packet in a timely manner, please complete all the Sections below, sign, date and return to your AmeriCorps Program Director.

(All members must fill out Member Information)

Section I: MEMBER INFORMATION		
Program Name:		City/State:
Member First Name:	Middle Initial:	Member Last Name:
Social Security Number::	Date of Birth (mm/dd/yyyy):	
Address:		Apt/Unit #:
City:	State:	Zip Code:

AmeriCorps health coverage eligibility requirement only for Full-time members

Section II: INSURANCE INFORMATION

Are you covered by any other private health insurance? ☐ **Yes** ☐ **No**

(Members with private health coverage are not eligible for AmeriCorps coverage. If covered, ***proof of coverage must be attached to this form and maintained on file.*** Acceptable proof of coverage is either a copy of your health insurance card or a letter from your health insurance carrier.)

If **NO,** AmeriCorps requires all members to enroll in AmeriCorps health coverage **UNLESS** proof of private health coverage is submitted.

Please sign, date and return to your AmeriCorps Program Director.

Enroll into AmeriCorps health coverage Enrollment Date: _____

Member Signature: _____ Date: _____

If **YES**, please fill out waiver of coverage below.

Section III: PRIVATE INSURANCE

WAIVER OF COVERAGE

By signing below, I hereby WAIVE participation in the AmeriCorps health benefits plan and agree that I will maintain my private health insurance plan to cover all medical expenses incurred while a member in the AmeriCorps program.

Member Signature _____ Date _____