**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 Coordinator. ***(Black or Blue Ink ONLY)***

*(All members must fill out Member Information)*

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| **Section I: MEMBER INFORMATION** |
| Program Sponsor 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 full time members are eligible for health insurance.*

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| **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 full-time members to enroll in AmeriCorps health coverage **UNLESS** proof of private health coverage is submitted. Please sign, date and return to your AmeriCorps Program Coordinator.

🞏 Enroll in AmeriCorps health coverage Enrollment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, please fill out waiver of coverage below.

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_