



Health Insurance EXIT FORM

In order to accurately process your exit and ensure that you are removed from coverage in a timely manner, please complete the information below in its entirety, sign, date and return to your AmeriCorps Program Coordinator. **(Black or Blue Ink ONLY)**

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:

Exit from AmeriCorps health coverage

Exit Date: _____

Member Signature: _____

Date: _____