



## Health Insurance New Enrollment 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)*

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:** *A Full Time member or a Half Time member that has elected to serve in a full time capacity must serve an average of 30 hours per week during each full calendar quarter in which the member serves in order to qualify for health care benefits.*

Section II: INSURANCE INFORMATION
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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 Coordinator.

Enroll into AmeriCorps health coverage      Enrollment Date: \_\_\_\_\_

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

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

Section III: PRIVATE INSURANCE
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### 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 \_\_\_\_\_