



Health Insurance Eligibility Agreement

By completing and signing this Agreement I, _____, understand that as a full-time AmeriCorps member, I may be eligible to enroll in the AmeriCorps health care plan, if I am not otherwise covered by a health care policy at the time of enrollment in AmeriCorps. I understand that health care coverage for family members is not available.

Please initial one:

_____ Enroll Me in the AmeriCorps Health Insurance Plan		
I am not currently enrolled in a health care plan and would like to enroll in the health care plan provided through the AmeriCorps program.		
_____	_____	_____
SSN#	DOB	Sex
_____	_____	_____
Print Last Name	Print First Name	

Address		

Start Date		

_____ Health Care Wavier
I have been offered coverage under the AmeriCorps Instructional Support Team medical plan, but I am declining coverage because I am covered by another health care plan and am, therefore, ineligible to enroll in the health care plan provided by the AmeriCorps program.
I understand that the only reason I will be able to obtain coverage under this plan in the future is, if through no fault of my own, I lose coverage and I apply to the plan within 31 days of loss. (If initialing #2, attach a photocopy of your ID card from your other insurance carrier.)
Insurance Company: _____ Coverage # _____

Member Signature

Date