

AmeriCorps Health Insurance

WAIVER OF COVERAGE

AmeriCorps requires all members to enroll in their health plan **UNLESS** proof of other coverage is submitted.

Member's Name: _____

Social Security No.: _____

I elect **NOT** to enroll in the AmeriCorps health plan because I am covered under the following:

Insurance Company: _____

Policy Number: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____

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

Signature: _____ Date: _____

A COPY OF YOUR INSURANCE CARD OR A LETTER FROM YOUR INSURANCE CARRIER MUST BE ATTACHED.

Please return this form to: Outsourced Administrative Systems, PO Box 33757, Indianapolis, IN 46203.

