Corporation for
NATIONAL &
COMMUNITY
SERVICE

AmeriCorps Health Benefits

RESCIND WAIVER OF COVERAGE

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

Member's Name: ____

Certificate, NPSID, or Social Security Number: __________________________

I elect to ***ENROLL*** in the AmeriCorps health plan because I am no longer covered under the following:

Insurance Company: ____

Policy Number: ____

Policy Holder's Name: ____

Policy Holder's SSN: ____

By signing below, I hereby **rescind my initial waiver** & would like to participate in the AmeriCorps Health Benefits Plan.

Signature: ________________________ Date: ________________________

PLEASE ATTACH A CERTIFICATE OF COVERAGE OR A LETTER FROM YOUR INSURANCE CARRIER

Return form to: Seven Corners, Inc. P.O. Box 3430 Carmel, IN 46082-3430 866.699.4186 f. 317.815.5984