Corporation for NATIONAL & COMMUNITY SERVICE

AmeriCorps*VISTA
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OTHER HEALTH COVERAGE QUESTIONNAIRE

In order to accurately process your claims and ensure that you receive the maximum benefits available, information regarding other health care coverage is needed. Please complete the information below, sign at the bottom of the form and return the form to the address below.

SECTION I: GENERAL INFORMATION

Cert Number: ____________________ **AmeriCorps NSPID:** ____________________

Your Name: ____________________ **Telephone Number:** ____________________

Your Address: ____

Street City State Postal Code

Do you have any other insurance coverage for health, dental, vision or Medicare?

☐ **YES** (If **YES,** please complete all sections below) ☐ **NO** (If **NO**, please sign form and return)

If this is an update to indicate you no longer have other coverage, please attach a certificate of coverage letter from your insurance carrier.

SECTION II: TYPE OF COVERAGE

Type of Coverage	Relationship to You
Health ☐ Group ☐ Individual	☐ Self ☐ Spouse ☐ Parent ☐ Other
Dental ☐ Group ☐ Individual	☐ Self ☐ Spouse ☐ Parent ☐ Other
Vision ☐ Group ☐ Individual	☐ Self ☐ Spouse ☐ Parent ☐ Other
☐ Medicare	☐ Self ☐ Spouse ☐ Parent ☐ Other

SECTION III: INFORMATION RELATED TO OTHER INSURANCE COVERAGE

____________________ Policyholder Name

____________________ Policyholder Date of Birth

____________________ Policy Number

____________________ Employer/Sponsoring Organization Name

__(_________)____________________ Employer/Sponsoring Organization Telephone

____________________ Policy Effective Date

____________________ Employer Street Address

____________________ City

__________ State

__________ Zip Code

____________________ Name of Insurance Company

____________________ Location of Insurance (City/State)

____(_________)____________________ Insurance Company Telephone

SECTION IV: POLICYHOLDER SIGNATURE

I permit any physician, pharmacist, hospital or other health care provider, any insurer, prepayment organization or other health plan provider to give the Corporation for National Service any medical information about me, including information about physical and mental health, medical history, any drug or alcohol benefits.

This authorization shall remain in effect until all matters relating to these claims are concluded. A copy of this authorization will be as valid as the original. I understand that I may receive a copy of this authorization if I ask for one in writing.

____ Policyholder Signature

_________/__________/_________ Date

Privacy Act Statement: This information is provided pursuant to Public Law 93-579 (Privacy Act of 1974) for AmeriCorps members completing Federal records and forms that solicit personal information. This authorization will be used to obtain information about an AmeriCorps member's medical history so that any medical claim filed by an AmeriCorps member can be processed expeditiously. No other uses will be made of this information. Effects of Non-Disclosure: Failure to authorize the release of any medical information may delay the processing of the medical claim.

Return completed form to: Seven Corners, Inc. P.O. Box 3430 Carmel, IN 46082-3430 866.699.4186 f. 317.575.2659

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AmeriCorps requires that all members provide information regarding other Health Care Coverage upon enrollment in the AmeriCorps Health Plan. Heath Care Coverage can consist of commercial insurance (Anthem, Blue Cross, Aetna, etc), as well as other federal or state benefit plans (Medicare, Medicaid or military benefits). This information will be requested on an annual basis while you are active in the AmeriCorps plan. This allows us to accurately process your claims and ensure that you receive the maximum health benefits available. Please complete this form whether you have other health coverage or if you do not participate under any other health care coverage.

You may complete this form by choosing one of the following methods:

1. Online by signing into your MyPlan* account at myplan.sevencorners.com or americorps.sevencorners.com, click on “Links”, then click on “MyPlan”.

   *MyPlan requires your MyPlan ID number and Pin to setup a new account. Your MyPlan ID and PIN will be provided in your AmeriCorps Welcome Package, mailed at the time of enrollment.

2. Send completed form via Fax to: (317) 575-2659
3. Send completed form via Email to: policy@sevencorners.com
4. Mail the completed form to:
   Seven Corners, Inc.
   P.O. Box 3430
   Carmel, IN 46082-3430

If you have any questions, please contact our Customer Service Department toll free at 1-866-699-4186.