



## **AmeriCorps Health Benefits**

### **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 benefits 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.**