



HEALTH CARE ACCEPTANCE/WAIVER FORM

All full-time AmeriCorps members are eligible to receive health insurance coverage at no cost to the member. AmeriCorps requires all members to enroll in their health plan UNLESS proof of other coverage is submitted.

Please select one:

_____ I am accepting the health insurance coverage provide through the **ASSET*AmeriCorps Program**. The **ASSET*AmeriCorps Program** will provide further information on health insurance coverage upon request.

_____ I elect NOT to enroll in the AmeriCorps health plan because I am otherwise covered. Therefore, I waive my health care benefit provided by the AmeriCorps program. Under this waiver, I will receive no health care coverage from the **ASSET*AmeriCorps Program**. I will maintain my other health insurance plan to cover all medical expenses. This waiver is effective on the date of signature. I understand that if I lose my current coverage during my term of service as a result of participating in the AmeriCorps program or through no deliberate act of my own, I may revoke this waiver. I understand that if I revoke this waiver, I am not entitled to receive that portion of the health care benefit that I elected to forego during the waiver period.

Insurance Company: _____

Policy Number: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____

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

Member Signature

Date

Member Name