Health Insurance
2019-2020

By completing this form I understand that I will be covered under an AmeriCorps sponsored health care program. Members with other health coverage as a subscriber or a dependent are not eligible for AmeriCorps coverage and must submit proof of coverage.

_____ I would like to enroll in the NDA Member Health Insurance Plan and am not otherwise covered by a different health insurance plan.

_____ I am WAIVING my opportunity for health insurance coverage and agree that I will maintain my own health insurance plan to cover medical expenses incurred while a member in the AmeriCorps program. (*Fill in name/city below and complete waiver form*)

Name: _____

Address: _____

_____

Sex: Male / Female

Date of Birth (Month/day/year): _____ /_____ /_____

Social Security Number: _____-_____-_____

Service City: _____

Primary Service Site: _____

Signature: _____ Date: _____

Reviewed: May 2019