Corpsmember Waiver of Coverage

Please note: A photocopy of your ID card from your other insurance carrier must accompany this form.

Name of Group **Group #**

Name of Participant

Date of Birth **Social Security #**

I have been offered coverage under The Corps Network Insurance plan, but I am declining coverage because:

☐ I am already covered by another plan as a subscriber or a dependent.

Insurance Company ____________________ Policy # ____________________

☐ Other: Please Explain ____

I understand that one of the following two conditions must be met in order to obtain coverage under this plan in the future.

1. If through no fault of my own, I lose my other coverage and I apply for the plan within 31 days of the loss.
2. If I have actively served continuously with the same organization for one full year and will continue actively serving beyond one year, I may enroll in the plan on my one year anniversary date.

____ ______________________

Signature Date