2026-2027 Health Insurance Form

****REQUIRED TO BE COMPLETED BY ALL FULL-TIME MEMBERS – EVEN IF DECLINING****

In order to accurately process your claims, information regarding other health insurance coverage is needed. Please complete the information below and then sign at the bottom of the form.

LAST NAME:_____ **FIRST NAME:**_____ **MI:**_____

LAST 4 DIGITS OF YOUR SOCIAL SECURITY NUMBER: _____

YOUR ADDRESS: _____

Do you currently have any health insurance coverage (dental and/or vision) including Medicare?

☐ **YES,** I have insurance coverage outside of AmeriCorps and do not need to enroll in an insurance plan.

☐ **NO,** I do not have coverage, am a full-time member, and would like to enroll in an insurance plan.

If you selected yes, please list the name(s) of the policyholder and the type of coverage below

HEALTH INSURANCE:

Health Insurance Provider:_____ Policy #: _____

Policyholder: ☐ Spouse ☐ Parent ☐ Other _____
(Relationship to policyholder)

Coverage Type: ☐ Group ☐ Individual

MEDICARE:

Health Insurance Provider:_____ Policy #: _____

Policyholder: ☐ Spouse ☐ Parent ☐ Other _____
(Relationship to policyholder)

Coverage Type: ☐ Group ☐ Individual

By signing, I attest the information provided on this form is accurate.

SIGNATURE:_____ **DATE:** _____