VHCB AmeriCorps

Health Insurance & Child Care Acceptance/Waiver

Last Name	First Name	MI	Gender	Address, State, Zip	Birthdate	SSN

I have been offered coverage under The Corps Network Insurance plan, and choose to:

___ Accept
___ Decline

If Declining:

☐ I am already covered by another plan as a subscriber or a dependent. A photocopy of your ID card or other proof of coverage from your health insurance carrier must accompany this form.

Name of Group | Group #

Name of Participant

Date of Birth | Social Security #

☐ 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**

CHILD CARE BENEFIT

I have been informed of the availability of child care benefits through AmeriCorps Care and choose to:

___Accept
___Decline

_____ _____

Signature **Date**