



Palouse-Clearwater Environmental Institute

Health Insurance Eligibility Agreement

By completing and signing this Agreement I, _____, understand that as a full-time AmeriCorps member, I may be eligible to enroll in the AmeriCorps health care plan, if I am not otherwise covered by a health care policy at the time of enrollment in AmeriCorps. I understand that health care coverage for family members is not available.

Please initial one:

_____ Enroll Me in the AmeriCorps Health Insurance Plan		
I am not currently enrolled in a health care plan and would like to enroll in the health care plan provided through the AmeriCorps program.		
SSN# _____	DOB _____	Sex _____
Print Last Name _____	Print First Name _____	
Address _____		
Start Date _____		

_____ Health Care Wavier
I have been offered coverage under the NCSP AmeriCorps medical plan, but I am declining coverage because I am covered by another health care plan and am, therefore, ineligible to enroll in the health care plan provided by the AmeriCorps programs.
I understand that the only reason I will be able to obtain coverage under this plan in the future is, if through no fault of my own, I lose coverage and I apply to the plan within 31 days of loss. (If initialing #2, attach a photocopy of your ID card from your other insurance carrier.)
Insurance Company: _____ Coverage # _____

Member Signature

Date

Medical Release Waiver

I (please print your name) _____
understand that I will be participating in a service work program and may be subject to risks and dangers, injury or illness which may occur in places which may, at times, be distant from medical personnel and facilities.

If any injury or illness occurs while serving with the Palouse-Clearwater Environmental Institute's AmeriCorps programs, I consent that first aid, medical, dental, surgical treatment or other arrangements, that may be necessary in connection with such injury or illness, can be administered and undertaken and will be under the control and responsibility of such persons, medical or dental personnel or facilities as are then available in the area and to which I am referred by Palouse-Clearwater Environmental Institute's AmeriCorps programs or its representatives.

Member's Signature _____ **Date** _____

Legal Guardian Signature _____ **Date:** _____
(if member is under 18)

Person to be contacted in the event of an emergency:

Name: _____ Home Phone: _____

Address: _____

Relationship: _____ Work Phone: _____

Alternate Contact: _____ Home Phone: _____

Relationship: _____ Work Phone: _____

Important Medical Information for Emergency Officials:

Are you currently under a physician's care for a medical condition? Yes No
If yes, what is the condition?

Are you currently taking any prescription medications? Yes No
If yes, please list:

Do you have any allergies? Yes No
If yes, please list:

Please explain any other factors we should know about in case of an emergency:

FOR EMERGENCY USE ONLY

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