AmeriCorps*VISTA
AmeriCorps*NCCC
National Service Fellows

NEW ENROLLMENT QUESTIONNAIRE

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

YOUR NAME: _____ **SOCIAL SECURITY NUMBER:** _____

YOUR ADDRESS: _____
Street City State Zip Code

SECTION I: GENERAL INFORMATION

Do you have any other insurance coverage for health, dental, vision or Medicare?

☐ **YES** (If **YES**, please complete all sections below.) ☐ **NO** (If **NO**, please sign form and return.)

NAME(S) OF POLICYHOLDER	RELATIONSHIP TO YOU	TYPE OF COVERAGE
	☐ **Policyholder**	**Health** ☐ Group ☐ Individual
	☐ **Spouse**	**Dental** ☐ Group ☐ Individual
	☐ **Parent**	**Vision** ☐ Group ☐ Individual
	☐ **Other**	☐ **Medicare**

SECTION II: INFORMATION RELATED TO OTHER INSURANCE COVERAGE

Policyholder Name _____ Policyholder Social Security Number ___ - ___ - _____ Policy Number _____

Employer / Sponsoring Organization Name _____ Employer / Sponsoring Organization Telephone ( ) - _____ Policy Effective Date _____

Employer Street Address _____ City _____ State _____ Zip Code _____

Name of Insurance Company _____ Location of Insurance Company (city/state) _____ Insurance Company Telephone ( ) - _____

SECTION III: POLICYHOLDER SIGNATURE

I permit any physician, pharmacist, hospital or other health care provider, any insurer, prepayment organization or other health plan provider to give the Corporation for National Service any medical information about me, including information about physical and mental health, medical history, any drug or alcohol benefits.

This authorization shall remain in effect until all matters relating to these claims are concluded. A copy of this authorization will be as valid as the original. I understand that I may receive a copy of this authorization if I ask for one in writing.

Policyholder Signature _____ Policyholder Telephone ( ) - _____ Date ___ / ___ / _____

Privacy Act Statement: This information is provided pursuant to Public Law 93-579 (Privacy Act of 1974) for AmeriCorps members completing Federal records and forms that solicit personal information. This authorization will be used to obtain information about an AmeriCorps member's medical history so that any medical claim filed by an AmeriCorps member can be processed expeditiously. No other uses will be made of this information. Effects of Non-Disclosure: Providing this information is voluntary; however, failure to authorize the release of any medical information may delay the processing of the medical claim.

Return to: Outsourced Administrative Systems, Inc. P.O. Box 33757 Indianapolis, IN 46203-0757 800.847.8217 f. 317.614.2136