{Member Enrollment Form}

This form may be used to advise IMG of your enrollment election under the AmeriCorps VISTA health benefit program. You may elect to enroll into the AmeriCorps VISTA Health Benefit Plan, the AmeriCorps VISTA Healthcare Allowance, or you may elect to waive participation in the benefit program altogether. All members are required to complete this form whenever there is a change in the status of your healthcare coverage as well as at the start of a new term. In order to accurately process your claims and insure that you receive the maximum benefits available, information regarding other health care coverage is needed.

1. Send completed form via email to: **vistacare@imglobal.com**
2. Mail: **IMG P.O. Box 88506 Indianapolis, IN 46208**
3. Send completed form via fax to: **(855) 851-2971**

If you have any questions, please contact us at **(855) 851-2974** or **(317) 833-1711**

*You may advise IMG of your initial enrollment option via your MyIMGVISTA account. Visit **americorpsvista.imglobal.com** for more information.*

Section 1: General Information (Must Complete)

NSPID or IMG Member ID (if known): _____

Name: _____ Telephone Number: _____

Date of Birth: _____ Enrollment/Notice Date: _____

Mailing Address: _____
Street Apt/Suite/Room/etc

_____
City State Postal Code

☐ This is my first time enrolling. ☐ This is a change to my healthcare coverage status.

Section 2: Current Healthcare Coverage Status

☐ I have other healthcare coverage and wish to enroll in the Healthcare Allowance plan. **Complete Sections 3, 4, and 6**

☐ I am exempt from the mandate to maintain healthcare coverage and DO NOT have any other healthcare coverage. I request enrollment in the Health Benefit Plan. **Complete Sections 4, 5, and 6**

☐ I am not exempt from the mandate and intend to obtain required healthcare coverage within the next 60 days. I request temporary enrollment into the Benefit Plan. I understand that I MUST provide IMG with proof of coverage within 60 days via an updated enrollment form. I understand that after 60 days, I will no longer have coverage under the AmeriCorps VISTA Health Benefit Plan. **Complete Sections 4 and 6**

☐ I choose to waive coverage through AmeriCorps VISTA Health Benefit Program but understand that I must provide proof of alternative coverage. **Complete Section 6**

Section 3: Information Related to Other Coverage

_____ _____ _____
Policyholder Name | Policyholder Date of Birth | Policy Number

_____ _____ _____
Policy Start Date | Policy End Date | Name of Insurance Company

_____
Insurance Company Address

_____ _____ _____ _____
City | State | Zip Code | Insurance Company Telephone

What type of coverage is the above? ☐ Indvidual ☐ Group ☐ Tricare ☐ Medicaid ☐ Medicare

Section 4: Authorization for Release of Information

I hereby authorize any physician, pharmacist, hospital or health care provider, any insurer, prepayment organization or other health plan provider to disclose medical information concerning me, including information about physical and mental health, medical history, and/or any drug or alcohol benefits to authorized representatives of International Medical Group, Inc. (IMG), its affiliates and subsidiaries. This authorization will remain in effect until revoked by me. 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.

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 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. Failure to authorize the release of any medical information may delay the processing of the medical claim.

Section 5: For Members Claiming Exemption

If your current Service Term within the AmeriCorps VISTA program began on or after 1/1/2015 and you are electing to enroll into the AmeriCorps VISTA Health Benefit Plan, you must provide your Exemption Certification Number (ECN). You must file and be approved for the exemption before enrolling into the Health Benefit Plan. For more information on exemptions please visit www.healthcare.gov/exemption.

ECN: _____

Section 6: Signature

By signing below I attest that the information I have provided and statements I have made on this form are true and accurate. I further consent to the authorizations contained herein.

Member Signature: _____ Date: _____/_____/_____