

Aetna Affordable Health ChoicesSM

AmeriCorps

WAIVER FORM

Name: _____

Social Security Number: _____

Date of Birth: _____

Date of Hire: _____

Phone Number: _____

I hereby certify that I am otherwise covered by a health insurance plan and therefore am not eligible to participate in the Health Care Insurance Plan provided by AmeriCorps. My signature below acknowledges that I waive coverage under this Plan.

Signature: _____ Date: _____

Plans are underwritten by Aetna Life Insurance Company.
Plans are administered by Strategic Resource Company (SRC).

WF V001 ED001 AMERICORPS (08/06)



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