CORPSMEMBER WAIVER OF COVERAGE FORM

Please note: A photocopy of your ID card from your other insurance carrier must accompany this form.

Name of Group	**Group #**

Name of Participant

Date of Birth	**Social Security #**

I have been offered coverage under The Corps Network Health Plan, but I am declining coverage that is provided at no cost to me, because:

☐ I am already covered by another plan as a subscriber or a dependent.

Insurance Company _____ Policy # _____

☐ Other: Please Explain _____

I understand that to obtain coverage under this plan in the future I must lose my other coverage through no fault of my own, and apply for the plan within 31 days of the loss.

_____ _____

Signature Date