AmeriCorps VISTA

Member Enrollment Form

Did you know you can complete your health benefit enrollment online via your MyIMGVISTA account? Please visit americorpsvista.imglobal.com for more information. If you are unable or prefer not to complete enrollment electronically, you may enroll by submitting this form.

You have three options in regard to your health benefit plan. You may enroll in one of the AmeriCorps VISTA benefits (the AmeriCorps VISTA Health Benefit Plan or the AmeriCorps VISTA Healthcare Allowance), or waive participation in the benefit program altogether. You are required to complete this form at the start of each new service term, as well as whenever there is a change in the status of your healthcare coverage. Timely enrollment and updates allow IMG to accurately process your claims and insure that you receive the maximum benefits available.

1. Send completed form via email* to: **VISTAcare@imglobal.com**
2. Mail: **International Medical Group ATTN: AmeriCorps VISTA Enrollment IMG P.O. Box 550, Farmington Hills, MI 48332**
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**

1 GENERAL INFORMATION *(MUST COMPLETE)*

NSPID or IMG Member ID (if known):		
Full Legal Name: *(Last, First, Middle)*		
Telephone:	Email:	
Mailing Address:		
City:	State/Country:	Postal/Zip Code:
Enrollment/Notice Date: __/__/__ (MM/DD/YY)	Date of Birth: __/__/__ (MM/DD/YY)	
This form is for:	❑ This is my first time enrolling ❑ I am updating my information ❑ I had other healthcare coverage end on: __/__/__ (MM/DD/YY)	

❑	I agree to the processing of my personal information to provide the services I have purchased, including to administer claims, and to receive member communications, in accordance with IMG's Privacy Policy.
❑	I agree to receive relevant information and other communications from IMG about Insurance coverages and service options. I understand that I can withdraw my consent at any time.

2 CURRENT HEALTHCARE COVERAGE STATUS

❑	I DO have other healthcare coverage and wish to enroll in the Healthcare Allowance plan in order to assist with the copays, deductibles, and coinsurance applied by my other plan. **Read and Complete Sections 3, 4, and 6**
❑	I DO NOT have any other healthcare coverage and need only limited benefits for accidents and injuries that occur during my VISTA service term. I request enrollment in the Health Benefit Plan. **Read and Complete Sections 4, 5, and 6**
❑	I intend to review options for other healthcare coverage within the next 60 days and I request temporary enrollment in to the Health Benefit Plan for 60 days. I understand that if I obtain other healthcare coverage, I MUST provide IMG an updated enrollment form within 60 days to complete enrollment on the Allowance Plan. If I do not obtain other coverage,I may be placed on the Benefit Plan. **Read and Complete Sections 4, 5, and 6**
❑	I do have other healthcare coverage but instead choose to waive any additional coverage through AmeriCorps VISTAHealth Benefit Program. I understand that I must provide proof of alternative coverage on this form. **Read and Complete Sections 3 and 6**

3 INFORMATION RELATED TO OTHER COVERAGE

Policy Holder Name:		
Date of Birth: __/__/__ (MM/DD/YY)	Policy Number:	
Policy Start Date: __/__/__ (MM/DD/YY)	Policy End Date (if known): __/__/__ (MM/DD/YY)	
Name of Insurance Company:		
Insurance Company Mailing Address:		
City:	State/Country:	Postal/Zip Code:
What type of coverage is the above? ❑ Individual ❑ Group ❑ Tricare ❑ Medicaid ❑ Medicare		

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.

5 IMPORTANT INFORMATION REGARDING THE VISTA HEALTH BENEFITF PLAN

Please be aware that the AmeriCorps VISTA Health Benefit Plan does not cover for care related to most pre-existing medical conditions and does not cover common routine preventative benefits you may find standard on most ACA-compliant health plans. You may find out you are eligible for more benefits by applying for Medicaid coverage, or for tax credits to pay for an affordable ACA compliant plan with more benefits at https://www.healthcare.gov/.

By completing enrollment in the VISTA Health Benefit Plan you agree to all plan terms and conditions outlined in the AmeriCorps VISTA Health Benefit Plan Member Guide.

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.

Employee Signature: X ______________________	Date: __/__/__ (MM/DD/YY)

**Notice on Electronic Communication and Privacy: Please submit these documents via secure means, such as encrypted email or by fax. If you choose to send the information via unsecure email, you are solely responsible for any subsequent data breach or data loss caused by your decision. To protect your private information, we recommend you consider using any secure or confidential/encrypted email sending options with your email service provider. You may also consider password protecting your documents and sending the password in a separate email.*

We are required by the Privacy Act of 1974 (5 U.S.C. 552a) to tell you what personal information we collect and how it will be used: Authorities – This information is requested pursuant to 42 U.S.C. 4955, Support services; 42 U.S.C. 12618, Authorized benefits for Corps members; and 45 CFR § 2556.320 - What benefits may a VISTA receive during VISTA service? Purposes – It is requested to manage and evaluate the health benefits programs offered to VISTA, NCCC, and FEMA Corps Members. Routine Uses – Routine uses of this information may include disclosure to (1) health care providers and insurance companies to provide care and coordinate payment, (2) contractors to assist with providing the health care benefit, and (3) federal, state, or local agencies pursuant to lawfully authorized requests. Effects of Nondisclosure – This request is voluntary, but not providing the information will likely affect your ability to receive your health care benefits.

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