AmeriCorps NCCC
Coverage Information Form

POWERED BY IMG

The AmeriCorps NCCC Health Benefit Plan is provided at no cost to you automatically upon your entry into service.

In order to accurately process your medical claims and ensure that you receive the maximum benefits available, information regarding other healthcare coverage is needed and should be provided to IMG at the beginning of each service term and/or whenever there is a change in your other coverage status. You may elect to waive participation in this benefit plan however keep in mind that participation is automatically granted at no cost to you.

1. Submit online via your MyIMG NCCC account. Visit: https://americorpsNCCC.imglobal.com
2. Send completed form via email* to: **NCCCcare@imglobal.com**
3. Mail: **International Medical Group ATTN: AmeriCorps NCCC Claims, P.O. Box 21605 Eagan, MN 55121**
4. 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**

Part 1. General Information

NSPID or IMG Member ID: *(located on your ID card)*		
Name: *(Last, First, Middle)*		Date of Birth: __/__/__ (MM/DD/YY)
Telephone Number:	Email Address:	
Mailing Address:		
City:	State/Country:	Postal/Zip Code:

Part 2. Current Healthcare Coverage Status

- ❑ I have no other healthcare coverage and will rely on the AmeriCorps NCCC Health Benefit Plan. **Complete Sections 4 and 5**
- ❑ I have other healthcare coverage and will coordinate benefit payment with the AmeriCorps NCCC Health Benefit Plan**. **Complete Sections 3, 4, and 5 - *Please remember that you will need to present both your primary ID card as well as your IMG AmeriCorps ID card to your provider at time of service.***
- ❑ I choose to WAIVE coverage through the AmeriCorps NCCC Health Benefit Plan. I understand this benefit is provided to me at no cost automatically upon entry into training or service. **Complete Sections 3 and 5**

**Coverage under the AmeriCorps NCCC Health Benefit Plan is secondary to other healthcare coverage except in the case of Medicaid, Medicare or TRICARE when it is primary. Please present all coverage ID cards to the provider at time of service.

Part 3. Other Healthcare Coverage / Coordination of Benefits*** Information

Policyholder Name: *(Last, First, Middle)*		
Policyholder Date of Birth: __/__/__ (MM/DD/YY)	Relationship to Policyholder:	
Name of Insurance Company: *(Please, indicate if Medicaid, Medicare, or TRICARE)*		
Insurance Company Address:		
City:	State/Country:	Postal/Zip Code:
Insurance Company Telephone Number:	Email Address:	
Policy or ID Number:	Your Coverage Start Date: __/__/__ (MM/DD/YY)	Policy End Date: __/__/__ (MM/DD/YY)

*** Coverage under the AmeriCorps NCCC Health Benefit Plan is secondary to commercial or private insurance coverage.

Part 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.*

Member Signature: X _____	Date: __/__/__ (MM/DD/YY)

Part 5. 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: 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.