

Enrollment application will not be processed without this form.

DECLARATION OF NON-COVERAGE

I, _____, understand that Coordinated Access To Community Health (CATCH) is not medical insurance and medical services provided to me under this program are donated by physicians and hospitals.

I understand that medical services available under this program are limited, and it is to my advantage to seek medical coverage from any other program available to me.

I declare that currently I am not eligible and do not have coverage from any of the following:

1. Public Aid/Medicaid
2. Medicare (including anyone who has been receiving social security disability payment for two years or more)
3. Veterans Benefits
4. Student insurance

I also declare that I am not covered by medical insurance from my employer.

I understand misrepresenting medical coverage will immediately terminate my participation in CATCH and may obligate me to become financially responsible for services given to me through the charity of physicians and hospitals.

I declare all enrolling members of my household are not eligible for or do not have medical benefits from any other source.

Signature

Date Signed

Print Name