

ENROLLMENT APPLICATION for the Christian Care Medi-Share® Program



P.O. Box 120099, West Melbourne, FL 32912-0099
(800) PSALM 23 (800-772-5623) | Fax (321) 722-5134

Before You Begin

• Have your credit card or checkbook in hand for Section 6

How did you hear about us?

Please include name and home phone #: _____

Please complete each section using black ink

1 Medi-Share Annual Household Portion Options

Pick your portion*: \$500 (only available for ages 18-29 on the single program) \$1,250 \$2,500 \$3,750 \$5,000 \$7,500 \$10,000

Have you or your spouse ever applied for membership before? YES NO

Number Applying: Adults _____ Children _____

I'm also interested in: Manna Christian Disability Sharing—www.mannacds.org

I have read the Medi-Share Guidelines (If you have not read the Guidelines you must read them online at www.medi-share.org or call (800) 772-5623 to receive a copy by mail.)

I understand that Medi-Share is not insurance.

* If you haven't already done so, visit www.medi-share.org and go to the programs page where you will be asked to enter how many people are applying and the birthday of the oldest person applying. Once you provide this information, you will see the monthly share amount for each Annual Household Portion.

2 Applicant's Information

NAME		Last	First	Middle Initial	TITLE
ADDRESS					
CITY		STATE		ZIP+4	
HOME PHONE		WORK PHONE		CELL PHONE	Best time to contact
FAX		E-MAIL		MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	

3 Vital Statistics of Applicants

APPLICANT NAME	Social Security Number	Weight	Height		Waist Measurement* In.	Birthdate - M/D/Y	Age	Sex	U.S.Citizen**
			Ft.	In.					
SPOUSE NAME								M / F	Y / N
CHILDREN'S NAMES								M / F	Y / N
								M / F	Y / N
								M / F	Y / N
								M / F	Y / N
								M / F	Y / N
								M / F	Y / N

Additional children listed on separate sheet.

* Waist measurement should be taken with a tape measure at the belly button with the abdomen relaxed – do not enter pants size! For adult applicants age 18 and older only.

** If not a U.S. citizen, please submit a copy of your green card or visa with this application in order to process.

4 Membership and Commitment

1 - I wish to apply for membership in the Christian Care Medi-Share® program. I understand that any false statements on or omissions from this form will be future cause for immediate termination from the Medi-Share® Program. I understand that there is limited sharing during the first month of membership, (see Guidelines VII D).

2 - I understand that Christian Care Ministry (CCM) matches a Medi-Share® member's medical need with other Members who have volunteered, in faith, to share in meeting needs through the biblical concept of Christian mutual sharing. I further understand that all money comes from the voluntary giving of Members, not from the Christian Care Ministry, and that the Christian Care Ministry is not liable for the payment of any medical bills. I will accept the decisions made during the Appeal Process by the "Seven Member Appeal Panel" described in the Guidelines and will bring no suit, legal claim or demand of any sort against CCM for unpaid medical expenses.

3 - I agree that in cases where all administrative appeals have been exhausted, any and all disputes will be settled exclusively by an arbitrator(s) in mandatory binding arbitration, not in a secular court. I understand that the mandatory binding arbitration process is governed by the United States Code and I agree that each party will bear their own costs and attorney's fees, with the cost of the arbitration to be divided equally between the parties.

4 - I understand that I will be responsible each month to access the member website, which identifies a fellow Christian who will be receiving my gift toward their medical need. I will endeavor to pray for this person and to give him or her encouragement by mail. I understand that my fellow believers in Christ are relying upon the receipt of my monthly share by the first of each month.

5 - I have carefully read and agree to abide by all provisions stated in the Medi-Share® Guidelines. I hold to the conviction that the Bible teaches that we are to strive for healthy bodies, that we are our brother's keeper, and that I have an obligation to share in my brother's needs (Acts 2:42-47; Gal.6:2; 1 John 3:16-17). All persons listed on this form believe that the body is the temple of the Holy Spirit, to be kept pure. We do not engage in sex outside of traditional Christian marriage. None of the persons listed on this form have used tobacco in any form or illegal drugs for the last 12 months; we commit to continue to abstain as members. We agree not to abuse legal drugs, including alcohol. I understand that when a family member chooses not to live by these principles, the family member is disqualified from membership and his or her needs will not be eligible for sharing.

6 - I understand that in order to determine the eligibility of the need for sharing when an illness or injury occurs, medical records may be required from providers who have diagnosed or treated the member. I understand and agree that no need will be shared if authorization for obtaining such medical records is withheld.

All adults on this application have a verifiable Christian testimony indicating a personal relationship with the Lord Jesus Christ. I declare that the information contained herein is complete and true to the best of my knowledge and that I affirm agreement to the above six commitments of membership.

Your Signature

Spouse's Signature

Date Signed

Print Name

Print Name

-- Unsigned or incomplete applications will be returned to the applicant for completion. --

5 Authorization for Release of Protected Health Information

1 - I authorize the disclosure of protected health information to include medical records, reports, pharmaceutical records, diagnostic test results, and lab test results.

2 - I understand that the following parties will receive this information about one or more of the applicants on this form in regard to enrollment in the proposed sharing program: Christian Care Ministry Medi-Share® program, its employees, and authorized agents.

3 - Those parties that receive protected health information may disclose it for purposes of treatment, payment, or operations of Christian Care Ministry. They may otherwise disclose information only as allowed or authorized by law.

4 - I understand that this protected health information is needed for assistance in determining membership eligibility for enrollment in the proposed sharing program and to verify eligibility of the needs of those on this application that are submitted in the future to Christian Care Ministry.

5 - Unless revoked earlier, this authorization will be valid for the life of the Medi-Share membership plus 18 months from the date of termination for all members listed on this application.

6 - I understand that I may revoke this authorization at any time by notifying Christian Care Ministry in writing at the address shown below, but if I do, it won't have any affect on any actions taken prior to receiving the revocation.

7 - I understand that this authorization is voluntary; I understand that I may get a copy of this form after signing it.

8 - I understand that if an organization I authorize to receive the information is not a health plan or healthcare provider, federal or state law may no longer protect the released information and it will no longer be private.

Your Signature

Spouse's Signature

Date Signed

6 Payment

Enclosed is the non-refundable application fee of \$50 to cover the cost of processing my application.

I understand that if I am accepted for membership, my one time membership fee of \$125 will be due with my first month's share. _____ (initial here)

Payment Method for my non-refundable application fee of \$50

- Check or Money Order made payable to Christian Care Ministry
 Please charge my: Visa MasterCard Diners Club

Card # - - -

Expiration Date /

3-digit security code on the back of your credit card

Signature _____

Send your application today to:

Christian Care Ministry
P.O. Box 120099
West Melbourne, FL 32912-0099
(800) PSALM 23 (800-772-5623)
Fax (321) 722-5134

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For Office Use Only: Document # _____
Pay Type _____
Amount _____
Date Received _____