

ENROLLMENT APPLICATION to add-on additional family member(s) to current membership



Before You Begin

- Please complete each section using black ink
- Have your Pastor and church's contact information in hand for Section 5

1 Programs

- I would like to:** Add additional family member(s) to the family membership
- Reason for add-on:** Adoption Marriage Childbirth Other
- Number Applying:** Adults _____ Children _____
- Have any of the applicants ever applied for Medi-Share before?** Yes No
- 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.

2 Member's Information please print

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 Add-on Applicants

Name	Social Security Number	Height Ft. In.	Weight	Birthdate - M/D/Y	Age	Sex	U.S. Citizen*
						M / F	Y / N
						M / F	Y / N
						M / F	Y / N
						M / F	Y / N
						M / F	Y / N

* Please submit a copy of your green card or visa with this application if you are not a US Citizen.

4 Church Contact Information

CHURCH NAME / DENOMINATION	PHONE	FAX	
COMPLETE MAILING ADDRESS	CITY	STATE	ZIP+4
CHURCH E-MAIL ADDRESS	NAME OF PASTOR OR CHURCH LEADER THAT WILL VERIFY TESTIMONY AND LIFESTYLE		

Contact will be made with your church official in order to verify your Christian testimony, lifestyle, and regular attendance. The information you provide here will be held confidential and will be available only to Christian Care Ministry and its agents in matters relating to your Medi-Share® application and membership.

NOTE: Verification must be done by a person not related to the applicant.

5 Membership and Commitment

1 - I wish to apply for membership in the 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, Inc. (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 CCM, and that CCM does not pay nor is it liable for the payment of any medical bills.

3 - I agree that in cases where all administrative appeals have been exhausted and after a Seven Member Appeal process, any and all remaining disputes will be settled solely as follows: by biblically-based mediation, not in a secular court, with each party to bear their own costs and attorney's fees, and with the mediation fee itself to be borne by CCM. If resolution of the dispute and reconciliation do not result from mediation, the matter shall then be submitted to an independent and objective arbitrator for binding arbitration. The parties agree that the arbitration process will also be conducted in accordance with the Rules of Procedure for Christian Conciliation, with each party to bear their own costs and attorney's fees, and with the arbitration fee itself to be borne by CCM. I agree that suing fellow Christians, including Christian ministries, is contrary to scripture; therefore, I will bring no suit, legal claim or demand of any sort against CCM in the civil court system, with the sole exception of enforcing any favorable arbitration award or mediated agreement.

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 the receipt of my monthly share by the first of each month enables timely sharing.

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; I 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, I have a responsibility to notify CCM. I also realize the family member may be 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. --

ATTENTION—Medi-Share is not insurance or an insurance policy nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other member will be compelled by law to contribute toward your medical bills. As such, Medi-Share should never be considered to be insurance. Whether you receive any amounts for medical expenses and whether or not Medi-Share continues to operate, you are always personally responsible for the payment of your own medical bills. Medi-Share is not subject to the regulatory requirements or consumer protections of your particular State's Insurance Code or Statutes.

6 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

Print Name

Print Name

For Office Use Only: Document # _____
Date Received _____