



Verification Form for Health Discount Eligibility

Please complete form for each adult Medi-Share 2.0 Member in the household,
except for adult children on family membership.

Applicant Name: _____ Member #: _____

Phone Number: _____ E-mail: _____

****Measurements must be taken and submitted within 90 days of HbA1c test.****

These measurements must be taken and entered by a credentialed health professional (Doctor, RN, RD, Chiropractor, Emergency Medical Service Personnel, or Fitness Professional – *not an immediate family member*).

NOTE – This application will not be processed without waist measurement verification. (Take a tape measure with you, if necessary)

Height (without shoes): _____ inches

Weight (without shoes): _____ pounds

Estimated weight of clothing during weighing: _____ lbs.

Waist Measurement (at *umbilicus; abdomen relaxed*) _____ inches

I have personally documented the entries for the above-named person and, to the best of my knowledge; the numbers I have entered are accurate.

Signature of Authorized Person: _____

Name of Authorized Person (please print): _____

Title: _____ Agency: _____

Office phone #: _____ Date measurements were taken: ____/____/____

I affirm that all of the above entries are accurately reported by the authorized person.

Signature of Applicant: _____ Date: _____

Mail the completed Verification Form to:

Christian Care Ministry

PO Box 674

Sterling IL 61081

(800) 264-2562 Fax: (321) 722-5138