Medi-Share®
Christian Care Medical Sharing

Health Incentive Information and Instructions

Participants who have chosen to live a healthy lifestyle and have impressive test results to prove it, may receive an incentive of up to **20%** on their monthly share amount. A participant must be a standard Medi-Share 2.0 participant to qualify for the health incentive (not a mandatory Health Partner). To see what your incentive will be if you qualify, go to *www.mychristiancare.org/medi-share-pricing-tool.aspx*.

In short, here's what you need to know. Read below for the specifics of these steps.

1. You must be a Medi-Share 2.0 participant, or in the Medi-Share application process (you cannot be a mandatory Health Partner). If you qualify during the application process, the Health Incentive will not be applied until after your first month of sharing.
2. Complete your request for the Health Incentive Test Kit.
3. Conduct HbA1c test, using kit obtained from CCM or at a licensed lab.
4. Go to health professional to document that you meet the specified health criteria for waist, and BMI, using the health verification form. The BMI is a number calculated using your height and weight.
5. Submit test results and completed health verification form.
6. Wait for results and determination!

To qualify for this incentive, you must meet specified health criteria, including HbA1c level, BMI and weight/waist measurement. At your expense, you must obtain certified testing to document your results and annually thereafter to qualify.

All adult Participants in the household must meet the following criteria to qualify for the incentive:

HbA1c levels	4.2 to 5.6
Waist Circumference	Less than 38" for men, less than 35" for women
BMI	Greater than 17.5 and less than 30
Health Partner	Cannot be a "mandatory" health partner

All adult participants will need to qualify (except adult children aged 18-22). If an applicant is pregnant, she must submit the requested information to apply, however, is not required to meet all criteria.

Included is your request for the test kit. Please fill out this form and be sure to order enough testing kits for each adult participant. The HbA1c test must either be done with the testing kit supplied by CCM (other testing kits are not acceptable), or a test done at a licensed lab where the blood is both drawn and tested (it must be a blood "draw," not "drop").

Then, simply return the test kit form and payment to Christian Care Ministry to the address provided, or to expedite your Health Incentive application, please fax it to (321) 722-5139. When we receive your application, we will send you the testing kit and the Health Incentive Verification form (included here as well) to be completed by a credentialed health professional (Doctor, RN, RD, Chiropractor, Emergency Medical Personnel, or Fitness Professional). Please note that measurements for height and weight cannot be taken by an immediate family member and must be taken and submitted within 90 days of HbA1c test. In addition, all results must be received by CCM prior to the 7th day of the month for the Health Incentive to be applied to the following month's share amount due.

Once the results are received, you will be notified if you meet the criteria for the Health Incentive. As always, please do not hesitate to call (800) 264-2562 if you have any questions.

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Verification Form for Health Incentive Eligibility

Please complete form for each adult Medi-Share 2.0 Participant in the household, except for adult children (age 18-22).

Applicant Name: ______________________________ CCM ID Number: ____________________

Phone Number: ____________________ Email: ______________________________

☐ Please check this box if you are pregnant or have given birth in the last twelve months. If pregnant, please note due date:_____________. If you have given birth in the last twelve months, please indicate date:_____________.

**A first-time Health Incentive applicant who is pregnant (or gave birth less than a year ago) may still qualify for the incentive and must submit these results, however, the criteria may be modified based on the pregnancy and due date (or day she gave birth). A pregnant member (or member who gave birth less than a year ago) renewing their Health Incentive is not required to submit these results, however, does need to complete this form indicating their due date (or date she gave birth) in order to continue receiving the Health Incentive.*

*****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: _______________ pounds

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 Number: ____________________ Date measurements were taken: ____ / ____ / ______

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

Signature of Applicant: ________________________________ Date: ____________________

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Request for Health Incentive Test Kit(s)

In order to qualify for a Health Incentive, each adult (except adult children age 18-22) must be enrolled in Medi-Share 2.0, submit a test kit and meet the health requirements. If either adult is a mandatory health partner, they are not eligible for the incentive.

1. Contact Information

Primary Head of Household Name: ____________________

CCM ID Number: ____________________ Phone Number: ____________________

Ship to: Address: ____________________

City: ____________________ State: __________ Zip: __________

2. HbA1c Test Kit Request (Cost for one kit is $23.)

Number of test kits requested: __________

3. Authorization for Use/Disclosure of Health Information

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the CCM designated lab ("Lab") to disclose the below-described health information during the term of this authorization to Christian Care Ministry, Inc., 505 N. John Rodes Blvd., Melbourne, FL 32934.

Purpose and Information to be Disclosed: I understand that the specific purpose of this Authorization is to allow Lab to provide the results of test(s) done on samples of my blood to Christian Care Ministry, Inc., and I hereby authorize Lab to disclose such results.

Term: This Authorization will remain in effect until Lab fulfills this request.

____________________ ____________________
Print Name | Print Spouse Name (if applicable)

____________________ ____________________
Signature | Date | Spouse Signature | Date

Please make additional copies of this form if requesting kits for more than 2 people.

4. Payment

Total Payment: __________

☐ Check or Money Order made payable to Christian Care Ministry

☐ Please charge my: ☐ Visa ☐ MasterCard

Card # ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiration Date ☐☐/☐☐ 3 digit security code ☐☐☐

Christian Care Ministry | P.O. Box 120099, West Melbourne, FL 32912 | (800) 264-2562 | Fax: (321) 722-5139