

APPLICATION to Change Program IMR Level



Before You Begin

- Please complete each section using black ink.
- Have your credit card or checkbook in hand for Section 6.

1 Programs

I would like to change to the \$250 IMR \$1,000 IMR \$10,000 IMR *(there is a \$75 fee to change program IMR level)*

I'm also interested in Manna Christian Disability Sharing.

I have read the Medi-Share 1.0 Guidelines.

(If you have not read the Guidelines you must read them online at www.MyChristianCare.org or call (800) 264-2562 to receive a copy by mail.)

I understand that Medi-Share is not insurance.

2 Household Information please print

NAME	Last	First	Middle Initial	TITLE
HOUSEHOLD NUMBER	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 complete only if changing from a higher program IMR to a lower program IMR

Name	Social Security Number	Weight	Height		Birthdate	Age	Sex
			Ft.	In.	M/D/Y		
APPLICANT NAME							M / F
SPOUSE NAME							M / F
CHILDREN'S NAMES							M / F
							M / F
							M / F
							M / F
							M / F
							M / F
							M / F

4 Medi-Share Commitment

1 - 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 VI B).

2 - I understand that Christian Care Ministry, Inc. (CCM) matches a Medi-Share member's medical bills 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 Medi-Share 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 an 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 does 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 website, which

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 commitments of membership.

identifies a fellow Christian who will be receiving my gift toward their medical bills. I will endeavor to pray for this person and to give him or her encouragement by mail. I understand that the payment 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 Medi-Share members. We agree not to abuse legal drugs, including alcohol, and have not abused them for the past 12 months. 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 Medi-Share and his or her bills will not be eligible for sharing.

6 - I understand that in order to determine the eligibility of the medical bills 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 medical bill will be shared if authorization for obtaining such medical records is withheld.

7 - I consent to the recording of all telephone calls to or from CCM.

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, including but not limited to, 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, Inc. ("CCM"), its employees and authorized agents.

3 - Those parties that receive protected health information may disclose it for purposes of treatment, payment, or operations of Medi-Share. They may otherwise disclose information only as allowed or authorized by law. These parties include insurers to which proposed member has applied or may apply, pharmacy benefit managers, physicians, hospitals, clinics or other medical related facilities, health care clearing houses or persons who perform tasks for them.

4 - I understand that this protected health information is needed for assistance in determining eligibility for enrollment in Medi-Share and to verify eligibility of the bills of those on this application that are submitted in the future.

5 - I understand that in, reviewing this application and during the course of my membership, it may be necessary or convenient for someone else to discuss my protected health information with a representative of CCM. Therefore, if married, I

hereby authorize the disclosure of my protected health information to my spouse. If I am 18 or older and participating under my parents' membership, I hereby authorize the disclosure of my protected health information to my parent(s). Further, beneath my signature line, I have listed additional person(s)* (if any) whom I authorize the disclosure of my protected health information to, including missionary organization representative(s) and English speaker(s) if I am not fluent in English.

6 - Unless revoked earlier, this authorization will be valid as long as the members listed on this application are enrolled in Medi-Share plus 18 months from the date that their membership ends.

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

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

9 - I understand that if an organization I authorize to receive the protected health 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

Authorized to discuss my protected health information: (Please Print Below)

6 Payment

Enclosed is the \$75 fee for changing program IPR level.

Payment Method

Check or Money Order made payable to Christian Care Ministry

Please charge my: Visa MasterCard Discover

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

FOR OFFICE USE ONLY: DOCUMENT # _____

PAY TYPE _____

AMOUNT _____

DATE RECEIVED _____

ATTENTION—Medi-Share is not insurance or an insurance policy nor is it offered through an insurance company. Neither is Medi-Share a discount health care or discount health card program. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other participant 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.