# Sharing Member Enrollment Application

A healthcare sharing ministry of Gospel Light Mennonite Church Medical Aid Plan, Inc.

## SECTION 1: PRIMARY APPLICATION/GUARDIAN INFORMATION

**Please print or type in black ink. Incomplete applications cannot be processed and will be returned.**

| | | | |
|---|---|---|---|
| Name (First, Middle, Last) | | Is each person listed a dependent of the Applicant? (See Sharing Guidelines) ☐ Yes ☐ No ☐ N/A | Existing medical insurance to continue after enrollment ☐ Yes ☐ No |
| Birthdate (Month/Day/Year) | Height | Weight | Gender (*Circle*) Male Female |
| Street Address | City | State | Zip |
| Social Security Number (*Optional*) | Employer Name | Occupation/Title | |
| Home Phone | Cell Phone | Email | |

## SECTION 2: SPOUSE'S INFORMATION

| | | | |
|---|---|---|---|
| Name (First, Middle, Last) | | Is each person listed a dependent of the Applicant? (See Sharing Guidelines) ☐ Yes ☐ No ☐ N/A | Existing medical insurance to continue after enrollment ☐ Yes ☐ No |
| Birthdate (Month/Day/Year) | Height | Weight | Gender (*Circle*) Male Female |
| Street Address | City | State | Zip |
| Social Security Number (*Optional*) | Employer Name | Occupation/Title | |

* Spouses who are applying for the Liberty Rise and Liberty Assist Sharing Programs must do so as two individuals, each with their own membership

## SECTION 3: DEPENDENT'S/CHILDREN INFORMATION

| | | | |
|---|---|---|---|
| Name (First, Middle, Last) | | Is each person listed a dependent of the Applicant? (See Sharing Guidelines) ☐ Yes ☐ No ☐ N/A | Existing medical insurance to continue after enrollment ☐ Yes ☐ No |
| Birthdate (Month/Day/Year) | Height | Weight | Gender (*Circle*) Male Female |
| ☐ Full Time College Student ☐ Internship ☐ Mission Field ☐ Disabled Dependent | | College/University | |
| Name (First, Middle, Last) | | | Existing medical insurance to continue after enrollment ☐ Yes ☐ No |
| Birthdate (Month/Day/Year) | Height | Weight | Gender (*Circle*) Male Female |
| ☐ Full Time College Student ☐ Internship ☐ Mission Field ☐ Disabled Dependent | | College/University | |
| Name (First, Middle, Last) | | | Existing medical insurance to continue after enrollment ☐ Yes ☐ No |
| Birthdate (Month/Day/Year) | Height | Weight | Gender (*Circle*) Male Female |
| ☐ Full Time College Student ☐ Internship ☐ Mission Field ☐ Disabled Dependent | | College/University | |

*Applicants with dependents are not eligible to enroll with the Liberty Rise Sharing Program. Dependents are not eligible for membership under the Liberty Assist Sharing Program.

## SECTION 4: ACKNOWLEDGMENTS

**PROGRAM IS NOT INSURANCE:** I acknowledge that I am applying for membership in Liberty HealthShare, a healthcare sharing ministry of Gospel Light Mennonite Church Medical Aid Plan, Inc., that is voluntary and cooperative and not insurance. I have read and understand any disclaimers to this effect and understand that there are no representations, promises or guarantees that my medical expenses will be paid. I also understand that any funds that I may receive for medical expenses do not come from an insurance plan, but are voluntary donations by the members.

**CHANGES TO GUIDELINES:** I acknowledge that the Sharing Guidelines in effect on the date of medical services supersede any spoken or verbal communication and all previous versions of the Sharing Guidelines. I also understand that with notice to the membership, the Sharing Guidelines may change at the preferences of the membership and/or the Board of Directors of Liberty HealthShare.

**MEMBERSHIP ENROLLMENT DUES REFUND:** I acknowledge that the membership enrollment dues will be refunded if all individuals on my application are declined for membership. I also understand that the membership enrollment dues will not be refunded if, in the course of applying for membership, I fail to respond written or verbal inquires from Liberty HealthShare for more than thirty (30) days.

**CALCULATION OF SUGGESTED MONTHLY SHARE:** I acknowledge that the Suggested Monthly Share Amount is calculated on the total number of members, the amount of medical expenses submitted for sharing and the administrative cost of operating the program. I further acknowledge that the Suggested Monthly Share Amount is calculated on a periodic basis as needed and is subject to change. I understand that the donation of the Suggested Monthly Share Amount is voluntary and that I am not obligated to send any money.

**RECEIVING WELL WISHES:** I acknowledge that if I receive voluntary contributions from members for my medical expenses, at my discretion, secure contact information may be reported to the contributor for the purpose of receiving well wishes and encouragement from the contributor if they choose to do so.

**APPLICATION ACCEPTANCE:** I acknowledge that Liberty HealthShare has the absolute discretion to accept, reject or modify my membership. I will not assume that my application has been accepted until I have received a written confirmation from Liberty HealthShare.

**ACCEPTANCE OF GUIDELINES:** I have read and understand the Sharing Guidelines and accept them as the guiding document for all interactions between members and for determining the eligibility of medical expenses that I may submit for sharing. If a difference of opinion should arise as to the use, application or interpretation of those Sharing Guidelines, I will follow the Dispute Resolution process outlined in the Sharing Guidelines for the resolution of any or all disputes.

**TWO MONTH WAIT:** I acknowledge that for the first two months after the Enrollment Effective Date as a Sharing Member, medical expenses for any reason other than accidents, acute illness or injury are not eligible for sharing among members.

**In Agreement of the Above Acknowledgments:**

| Applicant/Guardian Signature | Spouse Signature (If Applicable) | Date |
|---|---|---|

# SECTION 5: STATEMENT OF SHARED CHRISTIAN BELIEFS

Liberty HealthShare is made up of like-minded individuals who voluntarily share one another's medical expenses. Our core ethical beliefs mobilize our actions and we relate to one another in community because of them. We ask that each member subscribe to the following Shared Christian Beliefs.

## I BELIEVE

I believe that my personal rights and liberties originate from God and are bestowed on me by God and are not concessions granted to me by governments or men.

I believe every individual has a fundamental religious right to worship the God of the Bible in his or her own way.

I believe it is my biblical and ethical obligation to assist my fellow man when they are in need according to my available resources and opportunity.

I believe it is my spiritual duty to God and my ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors or habits that produce sickness or disease to myself or others.

I believe it is my fundamental right of conscience to direct my own healthcare, in consultation with physicians, family or other valued advisors, free from government dictates, restraints and oversight.

**I hereby agree to share in accordance with the above Statement of Shared Christian Beliefs:**

| Applicant/Guardian Signature | Spouse Signature (If Applicable) | Date |
|---|---|---|

## SECTION 6: SHARE AMOUNT CALCULATOR

**Please select one of the Liberty HealthShare Program options below.**

### Liberty Unite

**Single**

- ☐ Under 35 $259
- ☐ 35 to 49 $309
- ☐ 50+ $359

$1,000 AUA*

**Couple**

- ☐ Under 35 $459
- ☐ 35 to 49 $509
- ☐ 50+ $649

$1,750 AUA*

**Family**

- ☐ Under 35 $849
- ☐ 35 to 49 $999
- ☐ 50+ $1239

$2,250 AUA*

$50 additional monthly share amount for each family member over 5 people


**No co-share** of eligible medical expenses up to $1,000,000 shareable per incident after (AUA)

### Liberty Connect

**Single**

- ☐ Under 35 $209
- ☐ 35 to 49 $239
- ☐ 50+ $279

$1,000 AUA*

**Couple**

- ☐ Under 35 $339
- ☐ 35 to 49 $389
- ☐ 50+ $489

$2,000 AUA*

**Family**

- ☐ Under 35 $639
- ☐ 35 to 49 $749
- ☐ 50+ $939

$3,000 AUA*

$50 additional monthly share amount for each family member over 5 people


**15% co-share** of eligible medical expenses up to $1,000,000 shareable per incident after (AUA)

### Liberty Essential

**Single**

- ☐ Under 35 $159
- ☐ 35 to 49 $179
- ☐ 50+ $219

$4,000 AUA*

**Couple**

- ☐ Under 35 $259
- ☐ 35 to 49 $309
- ☐ 50+ $379

$8,000 AUA*

**Family**

- ☐ Under 35 $499
- ☐ 35 to 49 $589
- ☐ 50+ $729

$12,000 AUA*

$50 additional monthly share amount for each family member over 5 people


**25% co-share** of eligible medical expenses up to $600,000 shareable per incident after (AUA)

**Liberty HealthShare's Rise, Unite, Connect and Essential Sharing Programs include access to our cost-saving tools.**
**The monthly share amount is based on the age of the oldest person on the membership whether or not he/she is the primary member.**

### Liberty Rise

**For Young Adults**

- ☐ 18 - 29 $119

### Liberty Assist

**For Retirees**

- ☐ 65 - 69 $85
- ☐ 70 - 74 $90
- ☐ 75 - 79 $120
- ☐ 80 - 84 $155
- ☐ 85-90 $182
- ☐ 91+ $273

$1,500 AUA* Annual Unshared Amount (AUA) you are responsible for before sharing can take place

*The Annual Unshared Amount for each program level must be met before medical expenses are eligible for sharing.
*$75 annual renewal dues for all five programs.

Please Note: Medical expenses for any reason, other than accidents, acute illness or injury, are not eligible for sharing among members within the first 2 months after enrollment effective date as a sharing member. The suggested monthly share amounts listed above are for informational purposes only. Do not enclose this amount with your application. After application acceptance, you will be informed of your effective date.

## SECTION 7: SIGNATURES

**With my signature below, I do hereby pledge to participate in the medical cost sharing program sponsored and administered by Liberty HealthShare and do hereby certify that I have provided truthful and accurate information to the best of my knowledge.**

Applicant/Guardian Name (Print)

Applicant/Guardian Signature _____ Date

**If Couple or Family applying for membership in the Liberty Unite, Liberty Connect or Liberty Essential Sharing Programs**

Spouse Name (Print)

Spouse Signature _____ Date

## SECTION 8: ENROLLMENT FEE | MONTHLY SHARE

☐ I select the following payment method for submitting my membership enrollment dues of $135.

☐ I hereby approve, permit and expect monthly auto-payment debiting from my account.

If I am approved for membership, I understand that the following information will be used for my ongoing monthly participation. I will be assigned my own online, secure 'ShareBox' to submit my monthly share amount directly to another member with medical expenses, other than the first two months of my suggested share amount which will be submitted directly to Liberty HealthShare.

## PAYMENT INFORMATION

**Payment Type**

☐ Debit Card
☐ Credit Card

**Card Network**

☐ Visa
☐ Mastercard
☐ Discover
☐ American Express

**Card Auto-Approval**

☐ Yes
☐ No

**Amount Due:**

☐ $135

**Credit Card/Debit Card Number:**

**Expiration Date: 00/0000** **CVV:**

**First Name On Card:**

**MI:** **Last Name On Card:**

**Billing Address:**

**City:** **State:**

**Zip:**

_____

**Authorized Signature**

## SECTION 9: APPLICATION CHECKLIST

☐ Complete each page and leave nothing blank. Use 'not applicable' (N/A) if necessary.

☐ Each adult applying must sign all signature areas.

☐ Submit completed Application and Enrollment Fee to Liberty HealthShare.

☐ Submit completed Medical History Questionnaire to Liberty HealthShare.

**FOR OFFICE USE ONLY**

Revd:___/___/___ Dues Pd:___/___/___ Adults:#____ S:☐/☐ C:☐/☐ F:☐/☐

Start:___/___/___ Ck#___/CC/WEB Children:#____

N'fied:___/___/___ Share Amt Due:_____ MS#:_____

**NOTICE:** This program is not an insurance company nor is it offered through an insurance company. This program does not guarantee or promise that your medical bills will be paid or assigned to others for payment. Whether anyone chooses to pay your medical bills will be voluntary. As such, this program should never be considered as a substitute for an insurance policy. Whether you receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills.

# Medical History Questionnaire

## PLEASE COMPLETE EVERY FIELD IN ITS ENTIRETY

**Answer each question for every person on the Application, including children, and for the entire period specified.**
**NOTICE**: Liberty HealthShare relies on the information you provide in this Questionnaire to determine whether you are eligible for membership. You must provide truthful and complete answers to the following questions to the best of your ability. You must fully answer all health history questions. If Liberty HealthShare approves your application for membership and later discovers that you withheld material information that would have been a determinative fact, we may rescind your membership. "Yes" answers will not necessarily cause an applicant to be denied membership, but may require further information to be provided on the Medical History Explanation section.

All questions must be answered or the application will be returned. If you cannot answer either "YES" or "NO" for a specific question, check the "NOT SURE" box. For example, you can check the "NOT SURE" box if you do not understand a medical term being used, are not sure whether you have or had a listed medical condition, cannot remember the exact time frame when you had a medical condition. For any question where you answer either "YES" or "NOT SURE" please provide the information requested in the Medical History Explanation section. Liberty HealthShare may need to contact you and ask further questions regarding your "YES" or "NOT SURE" responses in order to process your application.

## APPLICANT'S INFORMATION

| | | | |
|---|---|---|---|
| Name (First, Middle, Last) | | | |
| Birthdate (Month/Day/Year) | Height | Weight | Gender (*Circle*)<br>Male Female |
| Street Address | City | State | Zip |
| Social Security Number (*Optional*) | Employer Name | Occupation/Title | |

## MEDICAL HISTORY (1 OF 3)

**Please check box for each answers below :**

| | | | |
|---|---|---|---|
| 1. Are you or a family member currently on any type of medication? | ☐ Yes | ☐ No | ☐ Not Sure |
| 2. Within the last 60 days, have you seen a health care provider(s) for any reason? Including any type of testing? | ☐ Yes | ☐ No | ☐ Not Sure |
| 3. Within the past 36 months, have you been hospitalized or treated in an urgent care or emergency room for any reason? | ☐ Yes | ☐ No | ☐ Not Sure |
| 4. (This question applies to females) Have you ever consulted with a health care provider or been diagnosed or treated for: | | | |
| A. Amenorrhea (absence of menses) | ☐ Yes | ☐ No | ☐ Not Sure |
| B. Any gynecological abnormalities | ☐ Yes | ☐ No | ☐ Not Sure |

# MEDICAL HISTORY (2 OF 3)

5. Do you currently have a PCP (Primary Care Physician)? ☐ Yes ☐ No ☐ Not Sure

6. Date of last physical and labs. Date:_____/_____/_____

7. Have you ever been diagnosed or treated for any type of cancer, leukemia, melanoma, or malignant tumor(s)? ☐ Yes ☐ No ☐ Not Sure

8. Within the past 36 months, have you ever consulted with a health care provider or been diagnosed with any of the following?

A. Angina, heart attack, irregular/increased heart rate, heart disease, hypertension, high cholesterol, phlebitis, stroke, circulatory or blood or bleeding disorders, sleep apnea? ☐ Yes ☐ No ☐ Not Sure

B. Diabetes, thyroid, or any other endocrine disorders? ☐ Yes ☐ No ☐ Not Sure

C. Recurrent pain (including back), joint disorders? ☐ Yes ☐ No ☐ Not Sure

D. Any type of neurological disorders, example: (seizures, epilepsy)? ☐ Yes ☐ No ☐ Not Sure

E. Any type of congenital heart disorders or birth defects? ☐ Yes ☐ No ☐ Not Sure

F. Liver, prostate or kidney disorders? ☐ Yes ☐ No ☐ Not Sure

9. Have you ever participated in a treatment program, consulted with a health care provider, been diagnosed with or treated for any psychological, emotional or behavioral disorders or addictions? Examples: OD, ADD/ADHD, Schizophrenia, Bi-Polar, Major Depression, Drug or Alcohol Abuse? ☐ Yes ☐ No ☐ Not Sure

10. Have you ever been diagnosed or treated for any type Hepatitis? ☐ Yes ☐ No ☐ Not Sure

If yes, which type? Please specify: _____

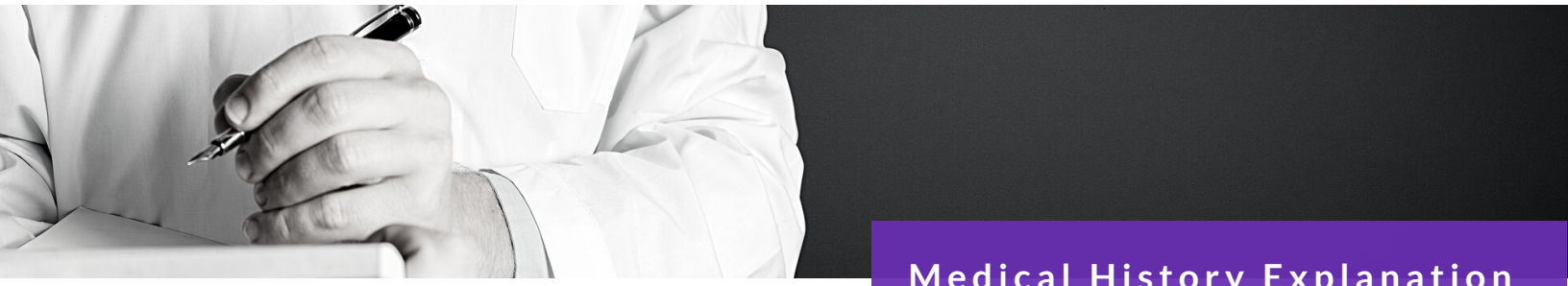
Date of last treatment:____/_____/_____

11. Have you ever been diagnosed with or treated for any if the following?

Check all that apply:

- ☐ Acquired immune Deficiency Syndrome
- ☐ (AIDS) AIDS Related Complex (ARC)
- ☐ Antiviral Therapy or Treatment
- ☐ Ankylosing Spondylitis
- ☐ Alzheimer's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Diverticulitis/Diverticulosis
- ☐ Emphysema
- ☐ Gaucher's Disease
- ☐ Hemophilia
- ☐ Kaposi Sarcoma
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Pneumocystis Carinii
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Scleroderma
- ☐ Ulcerative Colitis

| | | | |
|---|---|---|---|
| 12. Are you a candidate for or have you ever received an organ or bone marrow transplant and/or have you ever donated an organ? | ☐ Yes | ☐ No | ☐ Not Sure |
| 13. During the past 36 months have you at any time smoked cigarettes, cigars, vaping, pipes or used any other form of tobacco? | ☐ Yes | ☐ No | ☐ Not Sure |
| 14. Within the past 36 months have you had any type of surgeries? | ☐ Yes | ☐ No | ☐ Not Sure |
| 15. Do you have any other medical conditions not listed above? | ☐ Yes | ☐ No | ☐ Not Sure |
| 16. Please select the number of alcoholic drinks you consume in an average week. (One beverage equals 12oz. beer, 4oz. wine, or 1oz. liquor) | ☐ 0-3 per week<br>☐ 8-14 per week | ☐ 4-7 per week<br>☐ 15+ per week | |



## Medical History Explanation

If you answered "YES" or "NOT SURE" to any questions in the Medical History Questionnaire, explain further using the space below. Include explanations for any applicant in this section by name for who you answered "YES" or "NOT SURE" including children. If extra space is needed, make a copy of this page and use as many separate pages as necessary. Please be complete in your responses.

| | | | |
|---|---|---|---|
| Question Number | | | |
| First/Last Name of Person Affected | | | |
| Describe Condition, Injury, Illness, Symptom or Diagnosis | | | |
| Month & Year that it Started | | | |
| Date of Complete Recovery (If Applicable) | | | |
| Types of Treatment Given Exact Name of Medications, Dosage & Frequency Prescribed | | | |
| Notes: | | | |

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

**I understand** that I have the right to revoke this authorization in writing unless Liberty HealthShare has taken any action in reliance upon it.

**I understand** that Liberty HealthShare has requested and will receive from me and my health care provider protected health information prior to my enrollment in Liberty HealthShare. Liberty HealthShare will use this information to determine whether I am eligible to enroll. I further understand that Liberty HealthShare will protect the confidentiality of that information in the same manner as all other protected health information Liberty HealthShare maintains and, if I do not enroll, Liberty HealthShare will not use or disclose the information Liberty HealthShare obtained for any other purpose.

**I understand** that Liberty HealthShare will make disclosures of my protected health information as necessary for my treatment. A doctor or health facility involved in my care may request some of my protected health information that Liberty HealthShare holds in order to make decisions about my care.

**I understand** that Liberty HealthShare will make disclosures of my protected health information as necessary for payment purposes. For instance, Liberty HealthShare may use information regarding my medical procedures and treatment to process and arrange for the payment of medical bills, to determine whether services are medically appropriate or to otherwise pre-authorize or certify services as eligible to be shared under Guidelines. Liberty HealthShare may also forward such information to another health plan that may also have an obligation to process and pay expenses on my behalf.

**I understand** that Liberty HealthShare will use and disclose my protected health information as necessary for health care operations which include peer review, business management, accreditation and licensing, utilization review and management, quality improvement and assurance, enrollment, voluntary disclosure of health conditions, compliance, auditing, and other functions related to my healthcare management. Liberty HealthShare may also disclose my protected health information to another health care facility, health care professional or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has, or had, a patient relationship with me.

**I understand** that certain aspects and components of Liberty HealthShare services and performed through contracts with outside persons or organizations, such as legal services, Medical Discount Organizations, Pharmacy Managers, etc. At times it may be necessary for Liberty HealthShare to provide some of my protected health information to one or more of these outside persons or organization who assist with health care operations. In all cases Liberty HealthShare requires these business associates to appropriately safeguard the privacy of my information.

**I understand** that Liberty HealthShare may communicate with me regarding my medical expenses, share amount, or other matters related to my health. If I am endangered when all or part of the information being sent to me is viewed by another person, I understand that reasonable requests to receive communications regarding my protected health information by alternative locations will be accommodated by Liberty HealthShare.

**I understand** that Liberty HealthShare may, from time to time, use my protected health information to determine whether I might be interested in or benefit from treatment alternative or other health-related programs, products or services which may be available to me as a member. Liberty HealthShare may use my protected health information to identify whether I have a particular illness, and contact me to advise me that, as a member, a disease management and/or wellness program may help me manage my illness or health condition.

**I understand** that this authorization is voluntary, that I may revoke it at any time, and that I may get a copy of this form after signing it.

**I hereby authorize the disclosure of my Protected Health Information to the following person(s). Check all that apply.**

☐ Parent(s) ☐ Spouse

Name: _____ Phone: _____

Name: _____ Phone: _____

☐ Other Name: _____ Phone: _____

☐ Children

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

**I authorize the above release:** _____ Date: _____

**With my signature below, I do hereby certify that I have provided truthful and accurate information to the best of my knowledge as directed on the Medical History Questionnaire and have provided truthful and accurate explanations as necessary on the Medical History Explanation page(s).**

_____
Applicant Name (Print)

_____ Date: _____
Applicant Name (Signature)

**IF COUPLE OR FAMILY**

_____
Spouse Name (Print)

_____ Date: _____
Spouse Name (Signature)

**MEDICAL HISTORY QUESTIONAIRE CHECKLIST**

**Complete each page in full. Leave nothing blank. Indicate 'Not applicable' (N/A) if necessary each adult applying must sign all signature areas.**

**MAIL COMPLETED APPLICATION AND MEMBERSHIP ENROLLMENT DUES TO:**

**Liberty HealthShare**
4455 Hills and Dales Rd. NW
Canton, OH 44708

Phone: 1-855-585-4237 | Fax: 216-456-8115

THIS IS FOR OFFICE USE ONLY*

Rev'd:____/_____/_____ Adults: # _____

Matched w/ Applicant: Y / N Children: # _____

N'fied:____/_____/_____ A or D