



PO Box 336
Montezuma KS 67867

Phone: 620-846-2286 Fax: 888-877-8825
Email: info@cha.faith

Enrollment Form

Name: _____ Email: _____

Cell Phone: _____ Home Phone: _____

Mailing Address: _____

City, ST, & Zip: _____, _____, _____

Please provide the following information for all family members whom you wish to enroll in the program. CHA Guidelines state that all family members must enroll unless they meet one of the acceptable exceptions on Page 10, e.g., they have employer-paid job coverage, state aid, etc.

Name _____ M F Birth Date _____ Social Security # _____

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Name _____ M F Birth Date _____ Social Security # _____

Name _____ M F Birth Date _____ Social Security # _____

Name _____ M F Birth Date _____ Social Security # _____

Please provide the following information for all family members whom you are NOT enrolling and your reason.

Name _____ M F Birth Date _____ Reason: _____

Name _____ M F Birth Date _____ Reason: _____

Name _____ M F Birth Date _____ Reason: _____

Name _____ M F Birth Date _____ Reason: _____

Name _____ M F Birth Date _____ Reason: _____

Name _____ M F Birth Date _____ Reason: _____

Choose your Medical Program:

(only choose one)

	<input type="checkbox"/> Program One	<input type="checkbox"/> Program Two	<input type="checkbox"/> Program Three	<input type="checkbox"/> Program Four
Annual Sharing Limit:	\$50,000	\$100,000	\$150,000	\$200,000
Sharing % after AMR/AFR:	70%	80%	80%	90%
Annual Member Responsibility (AMR):	\$5,000	\$2,500	\$1,000	\$500
Annual Family Responsibility (AFR)	\$10,000	\$5,000	\$2,000	\$1,000

Choose Optional Dental and/or Vision Additions:

select this checkbox if you would like your children ages three and under to be excluded from your Optional Additions selection(s)

	<input type="checkbox"/> Dental Sharing	<input type="checkbox"/> Vision Sharing
Annual Sharing Limit:	\$8,000	\$1,000
Sharing % after AMR:	80%	80%
Annual Member Responsibility (AMR):	\$150	\$150

Effective date to begin CHA: _____ (no earlier than the 1st day of the current month)

Other current health coverage (if any): _____

If your other current health coverage is set to terminate, when is the termination date? _____

Have you previously been enrolled in CHA? Yes No

Are you a U.S. resident? Yes No

If not, what is your reason for enrolling in CHA? _____
(CPS Unit, Teaching school, etc.)

Name of congregation where you currently have your membership: _____

If someone else will be paying your monthly contributions (such as your employer), please list them below:

_____	_____	_____	_____	_____
Name	Address	City	State	Zip

I wish to receive correspondence such as contribution notices and Summaries of Sharing via:
 Email Postal service Both (if no box is checked, "Both" will be used until we are notified differently)

I agree to receive occasional information from CHA via SMS or other electronic methods:
 Yes No (if neither box is checked, "Yes" will be used)

By signing below, I acknowledge that I understand the following points:

(1.) Medical providers should be shown my CHA card and asked to send my medical bills directly to CHA, and I will only self-pay if I'm required, or if this has been otherwise arranged with CHA.

(2.) I have read, and do accept, the HCSM disclosure for my state, found online at www.cha.faith under the "Enrollment" tab.

Signature of Head of Household (or Responsible Party): _____ Date: _____