Enrollment Form

Christian Health Aid
...sharing makes a difference...

PO Box 336
Montezuma KS 67867

Ph: 620-846-2286 Fax: 888-977-8825
Email: membersupport@cha.faith

Today's Date _____

Telephone _____ Fax _____ Email _____

Name _____

Mailing Address _____

City, ST, Zip _____, _____ _____

SECTION A

Please provide information for all family members whom you wish to enroll in the program. CHA Guidelines state that all family members, except those of age or living apart, must enroll unless they have employer paid job coverage or state aid.

01 Name _____ ☐ M ☐ F Age _____ Birth Date _____ Social Security # _____
First name only

02 Name _____ ☐ M ☐ F Age _____ Birth Date _____ Social Security # _____
First name only

03 Name _____ ☐ M ☐ F Age _____ Birth Date _____ Social Security # _____
First name only

04 Name _____ ☐ M ☐ F Age _____ Birth Date _____ Social Security # _____
First name only

05 Name _____ ☐ M ☐ F Age _____ Birth Date _____ Social Security # _____
First name only

06 Name _____ ☐ M ☐ F Age _____ Birth Date _____ Social Security # _____
First name only

07 Name _____ ☐ M ☐ F Age _____ Birth Date _____ Social Security # _____
First name only

08 Name _____ ☐ M ☐ F Age _____ Birth Date _____ Social Security # _____
First name only

09 Name _____ ☐ M ☐ F Age _____ Birth Date _____ Social Security # _____
First name only

Other current health coverage _____ Effective date _____

Section B

Have you previously been enrolled in CHA? ☐ Yes ☐ No
If so, list an approximate date when your membership was terminated _____

Effective date to enter CHA: _____
(must be the beginning of a month, and no earlier than the 1st day of the current month)

Section C

Name of congregation where you currently have your membership _____

Section D

Mark your sharing choice below

☐ Traditional Sharing

☐ Add Dental Sharing Program $150 Annual Member Responsibility $1000 Annual Maximum

☐ Add Vision Sharing Program $150 Annual Member Responsibility $1000 Annual Maximum

Dental and Vision options are available with the Traditional Sharing only

☐ Emerald Care Sharing

☐ Diamond Care Sharing

☐ Add ExtenCare *ExtenCare is available with Emerald Care Sharing or Diamond Care Sharing only*

Section E

If a 3rd party will be paying your monthly shares, please list them below:

Name _____

Address _____

City, State, Zip _____, _____ _____

By signing below, I acknowledge that I understand the following points: If I participate in the Traditional Sharing, medical providers are free to send my medical bills directly to CHA. If I participate in the Diamond Care Sharing or Emerald Care Sharing, CHA will not accept direct billings from providers, but rather they will need to send the bills to me and I will be responsible to forward them to CHA with the proper self-pay documentation as per CHA's Guidelines. **I have read and accepted the disclosure for my state.** https://theaidplans.us/cha-forms/HCSM_State_Disclosures.pdf

Signature of responsible person _____