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

PO Box 336
Montezuma KS 67867

Phone: 620-846-2286 Fax: 888-879-0324
Email: membersupport@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 # _____

Name _____ ☐ M ☐ F Birth Date _____ Social Security # _____

Name _____ ☐ M ☐ F Birth Date _____ Social Security # _____

Name _____ ☐ M ☐ F Birth Date _____ Social Security # _____

Name _____ ☐ M ☐ F Birth Date _____ Social Security # _____

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: _____

Mark your program choice below:

1. ☐ Traditional Sharing

   ☐ Add optional Dental Sharing Program

   ☐ Add optional Vision Sharing Program

   Dental and Vision options are available with Traditional Sharing only

2. ☐ Diamond Care Sharing

   ☐ Add optional ExtenCare

   ExtenCare is available with Emerald Care Sharing or Diamond Care Sharing only

3. ☐ Emerald Care Sharing

   ☐ Add optional ExtenCare

   ExtenCare is available with Emerald Care Sharing or Diamond Care Sharing only

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

Other current health coverage (if you have any): _____ **Effective date:** _____

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

Name of congregation where you currently have your membership: _____

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

Name _____

Address _____

City, State, Zip _____, _____ _____

I wish to receive future sharing notices and other billing information (including ACH change notices) via:
☐ Email ☐ Postal service (if no box is checked, "Email" will be default)

I agree to receive occasional information from CHA via SMS or other electronic methods:
☐ Yes ☐ No (if no box is checked, "Yes" will be default)

By signing below, I acknowledge that I understand the following points: (1) If I participate in the Traditional Sharing, medical providers should send my medical bills directly to CHA, and I will only self-pay if I'm required. If I participate in the Diamond Sharing or Emerald Sharing, CHA will not accept direct billing from providers (except for special situations agreed upon by CHA), but rather they will need to send the bills to me, and I will be responsible to send them to CHA with the proper self-pay documentation as per CHA's Guidelines. (2) I have read, and do accept, the HCSM disclosure for my state, found online at www.cha.faith under the "Application" tab, or at this link: https://theaidplans.us/cha-forms/HCSM_State_Disclosures.pdf.

Signature of Head of Household (or Person Responsible): _____ **Date:** _____