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

2024 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: _____

Choose your Medical Program: (only choose one)				
	☐ Program One	☐ Program Two	☐ Program Three	☐ 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)			
	☐ Dental Sharing	☐ 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: _____
(Must be the beginning of a month, and 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

Name of congregation where you currently have your membership: _____

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

Name _____

Address _____

City, State, Zip _____, _____ _____

I wish to receive correspondence such as contribution notices/ACH change notices and Summaries of Sharing 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) 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: _____