APPLICATION PROCESS FOR NEW APPLICANTS

1. New applicant fills out member application and Medical Questionnaires* in its entirety for themselves or family. *(All pages must be completed along with all medical information listed on page 3 of application.)*
2. New applicant submits their application* along with fees** to Altrua HealthShare online or you may click on button below to submit application by mail.
3. Once Altrua HealthShare receives the application* and fees, new applicant will be contacted by phone or email to confirm receipt of application.
4. New applications will go through the approval process pending test results, limitations, etc.
5. If the new applicant decides to withdraw their application they must contact Altrua Health- Share directly.
6. If the new applicant has membership limitations that apply, new applicant must sign the membership limitations document prior to membership being effective.
7. If new applicant accepts terms of membership, new applicant will be contacted by phone or email advising them of their acceptance and effective date.
8. A new member welcome packet will be mailed to the address of the new member.
9. Membership ID cards will be mailed separately to new member once completed depending on approval date.
10. For any questions regarding a new membership:

    www.altruahealthshare.org, *(see FAQ's or Member Guidelines)*
    Email: enroll@altruahealthshare.org
    Call: (888) 244-3839

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* Please make sure if you're 40 or older, you have included the proper test results requested

** Payment Options: Online ACH, Online Credit Card, traditional check

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Altrua HealthShare ...caring for one another

APPLICATION
For Membership

Carry each others burdens and in this way you will fulfill the law of Christ. Galations 6:2

Refer to the Altrua HealthShare membership guidelines for the definitions of the underlined terms that are used throughout the application. If you do not have a copy of the guidelines, contact Altrua HealthShare. Please print or type in black ink. Incomplete applications cannot be processed.

Name (Last, First, Middle) (When a man is applying with his wife and/or children, his name must go here)				
Birthdate (Month/Day/Year)		Height	Weight	Sex
Street Address or P.O. Box		City	State	Zip
Social Security Number	Employer	Occupation/Title		
Home Phone	Work Phone	E-mail		

Is each person on the application a U.S. citizen? Yes No If no, how long in the U.S. ______________________________

Please choose your membership type: **Standard** **Gold** **Silver**

Advantage **Gold** **Silver**

If spouse and children are applying for the membership, list their names and information here:

Spouse Name (Last, First, Middle)				
Birthdate (Month/Day/Year)		Height	Weight	Sex
Street Address or P.O. Box		City	State	Zip
Social Security Number	Employer	Occupation/Title		
Child Name (Last, First, Middle)		Social Security Number		
Birthdate (Month/Day/Year)		Height	Weight	Sex
Child Name (Last, First, Middle)		Social Security Number		
Birthdate (Month/Day/Year)		Height	Weight	Sex
Child Name (Last, First, Middle)		Social Security Number		
Birthdate (Month/Day/Year)		Height	Weight	Sex
Child Name (Last, First, Middle)		Social Security Number		
Birthdate (Month/Day/Year)		Height	Weight	Sex
Child Name (Last, First, Middle)		Social Security Number		
Birthdate (Month/Day/Year)		Height	Weight	Sex
Child Name (Last, First, Middle)		Social Security Number		
Birthdate (Month/Day/Year)		Height	Weight	Sex

MEDICAL HISTORY QUESTIONNAIRE

APPLICATION

INSTRUCTIONS: Answer each question for every person applying, including children, and for the entire time period specified. Examples given (e.g.) are for illustrative purposes only and are not all inclusive. Any past or present symptoms significant enough to mention to a physician must be noted on the application. Upon discovery, inaccurate or untruthful responses may result in a retro-active exclusion of a condition or a retro-active denial of an applicant. "YES" answers will not necessarily cause an applicant to be rejected, but will require further information on the Medical History Explanation page.

1. Do you (or any applicant in your family) currently have any of the following conditions?

Alzheimer's Disease
Autism Spectrum Disorders
Cancer
Cerebral Palsy
Cholera
Chronic Kidney Disease
Chronic Obstructive Pulmonary Disease
Cystic Fibrosis
Dementia
Diabetes Type I
Down's Syndrome
Emphysema
Fragile X Syndrome
Hepatitis (Chronic Viral B & C)
HIV/AIDS
Lyme's Disease
Muscular Dystrophy
Parkinson's Disease
Schizophrenia, Paranoia, or Psychosis
Sickle-Cell Disease
Spina Bifida
Typhoid

2. Have you (or any applicant in your family) used illegal drugs within the last 12 months?

YES **NO**

3. Have you (or any applicant in your family) used tobacco or nicotine related products (i.e. vapor, e-cigarettes, chewing tobacco, cigars) within the last 12 months?

YES **NO**

4. Is anyone applying currently pregnant or suspect they may be?

YES **NO**

5. Do you (or any applicants) currently undergo immunotherapy treatment for allergies?

YES **NO**

6. Have you (or any applicant in your family) ever been diagnosed with a mental illness or condition (i.e. depression, anxiety, bi-polar disorder)?

YES **NO**

7. Have you (or any applicants) been diagnosed with Cancer within the last 10 years?

YES **NO**

8. Do you (or any applicants) currently have or ever been diagnosed with Type II Diabetes?

YES **NO**

9. Do you (or any applicant) currently suffer from or ever been diagnosed with Migraines?

YES **NO**

10. Do you (or any applicants) currently have or ever been diagnosed with an auto-immune disease?

YES **NO**

11. Do you (or any applicants) currently have or ever been diagnosed with an infectious or parasitic disease?

YES **NO**

12. Do you (or any applicants) currently have or ever been diagnosed with a nutritional deficiency?

YES **NO**

13. Do you (or any applicants) currently have or ever been diagnosed with an endocrine or metabolic disorder?

YES **NO**

MEDICAL HISTORY QUESTIONNAIRE

APPLICATION

14. Do you (or any applicants) currently have or ever been diagnosed with a disease or condition relating to the nervous system or sense organs?

YES NO

15. Do you (or any applicants) currently have or ever been diagnosed with an eye condition or disease?

YES NO

16. Do you (or any applicants) currently have or ever been diagnosed with a respiratory condition or disease?

YES NO

17. Do you (or any applicants) currently have or ever been diagnosed with a digestive system condition or disease?

YES NO

18. Do you (or any applicants) currently have or ever been diagnosed with a condition or disease relating to the reproductive or urinary systems?

YES NO

19. Do you (or any applicants) currently have or ever been diagnosed with a skin condition or disease?

YES NO

20. Do you (or any applicants) currently have or ever been diagnosed with a condition or disease of the musculoskeletal system?

YES NO

21. Do you (or any applicants) currently have a tumor or abnormal benign growth?

YES NO

22. Do you (or any applicants) currently have or ever been diagnosed with a condition or disease of the circulatory system?

YES NO

23. Do you (or any applicant) currently have an implant/hardware, prosthesis, or monitoring device? If so, which type?

YES NO

24. Have you (or any applicant) ever had a surgical operation within the last 10 years? Please do not include tonsil removal, adenoid removal, gallbladder removal, or appendix removal or any surgeries related to a cancer diagnosis?

YES NO

MEDICAL HISTORY QUESTIONNAIRE

Medical needs related to any of the cancers listed below will be eligible for sharing after your first year of membership, providing clean test results were received by Altrua HealthShare within 30 days of the effective membership date, or 1 year from the date that Altrua HealthShare receives and approves clean test results.

Male members, age 50 and over, are required to get a PSA blood test every two years from the date of last negative test result.

Female members, age 40 and over, are required to get the below screening tests every two years from the date of last negative test result, while on the membership: mammogram, or ultrasound in place of mammogram, and pap-smear with pelvic exams for female members.

Failure to obtain the biennial tests listed above will render future needs for breast, cervical, endometrial, ovarian and prostate cancer ineligible. The biennial tests must be performed within 24 months of their last clean test result and submitted to Altrua HealthShare.

By checking this box I acknowledge the above information is true and accurate, any information that is determined to be inaccurate may result in a medical need being ineligible for sharing.

By checking this box I acknowledge that I understand the testing requirements listed above based upon my current and future age

Altrua HealthShare
Altrua HealthShare

MEDICAL HISTORY EXPLANATION
MEDICAL HISTORY EXPLANATION

APPLICATION

If you answered "YES" to any question in the Medical History Questionnaire (page 2), explain further using the chart below. Be sure to use the "correct' example as your guide. You may include explanations for all family members on this page, or make copies and use separate pages for each family member. Additional space is provided on the back side of this page.

Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment Given, and Medications Prescribed
		What is it?	Date that it Started	Date of Recovery (if applicable)		
B	Mr. Doe	blood pressure	1993	N/A	N/A	prescription
INCORRECT EXAMPLE						
I. B.	John Doe	high blood pressure	4/93	none	no, ongoing	40 mg Atenol once a day
CORRECT EXAMPLE						

ESCROW INSTRUCTIONS, SIGNATURES AND APPLICATION CHECKLIST

APPLICATION

MEMBERSHIP ESCROW INSTRUCTIONS

I, the membership participant, direct Altrua HealthShare to hold in escrow, as escrow agent, all membership monthly contributions that I deliver to Altrua HealthShare and then to distribute all monthly contributions pursuant to the following escrow instructions and in the following order:

(1) First, to pay the expenses of operating the membership, including all of Altrua HealthShare's needs necessary to provide for the continued viability of the membership;
(2) then, to pay eligible needs pursuant to the guidelines as modified from time to time by Altrua HealthShare and as interpretes and applied by Altrua HealthShare;
(3) then in the event the membership is to be terminated, and after Altrua HealthShare determines that the funds held in escrow are sufficient to pay for the items listed above, any remaining funds shall be disbursed to qualified charities, as determined by Altrua HealthShare.

Altrua HealthShare may deposit or otherwise hold the escrowed contributions in one or more common bank accounts with escrowed contributions from other membership participants, until they are distributed pursuant to these instructions. Interest or other earnings on the escrowed monthly contributions shall become escrowed monthly contributions and shall be held and disbursed pursuant to these instructions. Altrua HealthShare shall not be obligated to invest the escrowed monthly contributions, provided, however, that if the escrowed monthly contributions are invested, Altrua HealthShare shall not be liable for substandard returns or for losses. Also, as a condition of receiving and distributing my monthly contributions Altrua HealthShare must report to me who my monthly contributions are given to.

This escrow arrangement does not create any rights in or benefits for membership participants or third parties to any escrowed monthly contributions.

SIGNATURES

With my signature below, I hereby verify each of the following:

(1) That I am aware of and understand each item under ACKNOWLEDGMENTS on page 4 of this application.
(2) That I live according to each item under the STATEMENT OF STANDARDS on page 4 of this application.
(3) That I commit to each item under COMMITMENTS on page 4 of this application.
(4) That I issue the ESCROW INSTRUCTIONS on page 5 of this application to Altrua HealthShare.
(5) That I have provided a true and accurate medical history in this application as directed on the Medical History Questionnaire and Medical History Explanation pages.
(6) I hereby authorize and permit true copies or facsimiles of this original application to be used in its place.

Applicant name (print)	
Signature	Date

Spouse name (print)	
Signature	Date

I/we hereby authorize the release of any requested medical information to Altrua HealthShare for the purpose of determining eligibility for acceptance into the HealthShare program for myself and any listed family members. This authorization will be valid for 90 days following the date indicated below.

Member: ______________________ Date:________

Spouse: ______________________ Date:________

CONTRIBUTION PAYMENT INFORMATION

ACH Information (Preferred Method)

I (we) hereby authorize Altrua HealthShare to initiate debit entries of my Application fee and Ministry fee from my financial institution:

◯ Checking Account ◯ Savings Account

Owner's Name (first, last)______________________

Financial Institution ______________________

Routing Number ______________________

Account Number______________________

I authorize Altrua HealthShare to make automatic withdrawals from the account for the amount of my recurring monthly contributions.

Signature: ______________________ Date: ________

Note: If a change to a financial institution is made, a new ACH authorization form will be needed (see forms and resources), (By placing my name on the signature line represents a signature itself)

Credit Card Information

◯ VISA ◯ MASTER CARD

Owner's Name (first, last) ______________________

Card Number______________________

Expiration Date: Month______ Year______

CVV Code ________

Application Fee $100.00 Ministry Fee $25.00

Signature: ______________________ Date:________

I (we) hereby authorize Altrua HealthShare to initiate debit entries of my Application fee, Ministry fee, Annual Renewal fee and recurring Monthly Contribution amount through the credit card information I have provided.