Membership Update Request Form

Only the Primary Member may make changes to a Membership. If you are not the Primary Member, please contact Member Support at **(855) 699-1274**.

PAGE 1: Demographic Changes (adding/removing a Dependent or Spouse)

For changes only to Program Level, Tier, or ISA, please proceed directly to Page 2.
For address changes only, please complete Section 1 of this Page 1, then proceed to Page 3.

SECTION 1. PRIMARY MEMBER INFORMATION

First Name:	M.I.:	Last Name:
Member ID Number:		Date of Birth:
Gender: ☐ Male ☐ Female		Requested Effective Date:
Only complete the remainder of this Section if <u>changing</u> your contact information		
Address:		City:
State:	Zip Code:	Phone Number:
Email Address:		

SECTION 2. REASON FOR DEMOGRAPHIC CHANGE (select all that apply)

☐	Marriage	☐	Death	☐	Birth or Adoption of Child
☐	Other (provide reason):				

SECTION 3. DEPENDENT INFORMATION

Add/Remove a Dependent or Spouse below. If the Primary Member is being removed, please contact Member Support at (855) 699-1274 because you must complete a new application to continue services for the remaining Dependents, and a new Primary Member must be named.

All Members over the age of 18 must sign this form. Adding or deleting individuals to or from the Membership is not considered a Program Change.

Dependent/Spouse Name	Relationship	Gender	Date of Birth	Tobacco/Vape in the last 12 months	Status
1.		☐ Male ☐ Female		☐ Yes ☐ No	☐ Add ☐ Remove
2.		☐ Male ☐ Female		☐ Yes ☐ No	☐ Add ☐ Remove
3.		☐ Male ☐ Female		☐ Yes ☐ No	☐ Add ☐ Remove
4.		☐ Male ☐ Female		☐ Yes ☐ No	☐ Add ☐ Remove

SECTION 4: AGREEMENT (Must agree to all for change to apply)

I understand and agree to the items below:

☐	Newborn expenses are Eligible for Sharing only if the baby was conceived after the mother's Active Date of Membership, the Membership has been continuously active during the pregnancy, and the Newborn is enrolled within 31 days after birth.
☐	Any newly added Dependent or Spouse will be subject to his or her own Waiting Periods, including the Pre-Existing Condition Waiting Period, starting from the date added to the Membership. Pre-Existing Condition Waiting Periods do not apply to Catastrophic365 Programs because Pre-existing Conditions are never Eligible for Sharing on that Program.
☐	I understand that all other Membership information currently in place, such as contribution frequency and payment arrangements, will transfer to and remain in effect for my Program.

<u>If you also want to make a change to your Program Level, Tier, or ISA, complete Page 2.</u>

<u>If you are not making any Program changes, proceed to Page 3.</u>

"Therefore encourage one another and build one another up, just as you are doing." **I Thessalonians 5:11 (ESV)**

PAGE 2: Program Changes (changes in Level, Tier, or ISA)

If you are only changing your contact information or adding/removing a Dependent or Spouse, you do not need to complete this Page and can proceed to Page 3.

SECTION 1. PRIMARY MEMBER INFORMATION

First Name:	M.I.:	Last Name:
Member ID Number:		Date of Birth:
Gender: ☐ Male ☐ Female		Requested Effective Date:

SECTION 2. REASON FOR PROGRAM CHANGE (select all that apply)

☐ New Medical Condition	☐ Financial Reasons	☐ We are Trying to Get Pregnant
☐ Other (provide reason):		
☐ Need Sharing Features Only Available on New Program (please describe):		

SECTION 3. PROGRAM SELECTION

Which Program are you currently enrolled in?	**Level:**	**Tier:**	**ISA:**

Please select a new Program below:

☐ **Level: OneShare Classic℠**				
Tier	☐ Basic	☐ Enhanced	☐ Crown	
ISA Amount	☐ $5,000 ☐ $7,500 ☐ $10,000	☐ $5,000 ☐ $7,500 ☐ $10,000	☐ $5,000 ☐ $7,500 ☐ $10,000	
☐ **Level: OneShare Catastrophic℠ or OneShare Catastrophic365℠ (*Circle which Program)***				
ISA Amount	☐ $5,000	☐ $10,000		
Maximum Limit Per Incident	☐ $150,000	☐ $250,000	☐ $500,000	
☐ **Level: OneShare Complete℠**				
FOR CURRENT COMPLETE℠ MEMBERS ONLY				
Tier	☐ Basic	☐ Enhanced	☐ Crown	
ISA Amount	☐ $5,000 / $15,000 ☐ $10,000 / $30,000	☐ $5,000 / $15,000 ☐ $10,000 / $30,000	☐ $5,000 / $15,000 ☐ $10,000 / $30,000	

SECTION 4. MEDICAL QUESTIONS

Since the Active Date of your current OneShare Health Membership, have you or any Dependent or Spouse on the Membership (or being added to the Membership) experienced symptoms of or been diagnosed with any of these conditions listed below? **Select all that apply.**

☐ Arthritis	☐ Crohn's Disease	☐ Anorexia	☐ Bulimia	☐ HIV / Aids
☐ Asthma	☐ Depression	☐ Heart By-Pass Surgery	☐ Hyperlipidemia	☐ None
☐ Congestive Heart Failure	☐ Diabetes I	☐ Heart Disease	☐ Hypertension / High Blood Pressure	
☐ COPD	☐ Diabetes II	☐ Herniated Disc	☐ Kidney Disease / Failure	

Since your initial Program Active Date, are you or any Dependent or Spouse on the Membership pregnant, or could be pregnant?	☐	Yes
	☐	No
Since your initial Program Active Date, have you or any Dependent or Spouse on the Membership had Cancer at any time?	☐	Yes
	☐	No
In the next 6 months, do you anticipate needing (for you or any Dependent or Spouse on the Membership) any advanced procedures (such as CAT / PET scan, EKG, EEG), any surgical procedure, or hospitalization?	☐	Yes
	☐	No

SECTION 5: AGREEMENT (Must agree to all for change to apply)

I understand and agree to the items below:

☐ I may make one Program Change per Program Year without paying an Application Fee. Any additional Program Change during the Program Year will require an Application Fee of $125 (excluding the Catastrophic365 Program, which has a $25 application fee).
☐ Any amount already met towards my Program Year ISA or Program Maximums will be credited.
☐ My Waiting Periods, including my Pre-Existing Condition Waiting Period, will not start over with a Program Change (but any added Dependent or Spouse will start his or her own Waiting Periods, including the Pre-Ex Waiting Period). Pre-Existing Condition Waiting Periods do not apply to Catastrophic365 Programs because Pre-existing Conditions are never Eligible for Sharing on that Program.
☐ I understand that all other Membership information currently in place, such as contribution frequency and payment arrangements, will transfer to and remain in effect for the Program elected in this Section.

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PAGE 3: Statement of Beliefs and Signature

SECTION 1. STATEMENT OF BELIEFS (Must agree to all for change to apply)	
Acknowledge each statement below:	
	We Believe in the authority of Scripture and the sanctity and dignity of every human life created by God with special meaning and purpose. ***II Timothy 3:16; Psalm 139:13-14***
	We Believe that every individual has the constitutional and religious right and duty to worship God in freedom. ***II Corinthians 3:17; U.S. Const. amend. I***
	We Believe and agree in the biblical and ethical principle of sharing with those who are less fortunate and who experience medical needs. ***Galatians 6:2***
	We Believe and agree that it is our responsibility to God and our fellow Members to engage in accountable, healthy living, and to avoid habits and behaviors which are harmful to the body. ***I Corinthians 6:19-20***
	We Believe in the power of prayer to save lives, to heal lives, and to unite our Members in common purpose and community, and we believe that prayer should be a fundamental practice of daily life. ***I John 5:14; Philippians 4:6-7***

By signing this form, you authorize OneShare Health to deliver your Membership Update determination to your email address on file.

SECTION 2: SIGNATURE(S) (The Primary Member and any newly added Members over the age of 18 must sign this form)	
ACKNOWLEDGMENT AND SIGNATURE	
I have fully read and understand the terms in this form. As the current Primary Member, I wish to request the above change(s) to my Membership as indicated on this form. The statements and answers set forth are true and correct to the best of my knowledge, and no information has been knowingly withheld. I understand OneShare Health, LLC reserves the right to deny Program change requests.	
PRIMARY SIGNATURE	**DATE**
DEPENDENT SIGNATURE (If Applicable)	**DATE**
DEPENDENT SIGNATURE (If Applicable)	**DATE**
DEPENDENT SIGNATURE (If Applicable)	**DATE**
DEPENDENT SIGNATURE (If Applicable)	**DATE**

Upon completion, please submit this form via one of the following:

By Email: **Billing@OneShareHealth.com**

By Fax: **(682) 477-8117**
Attn: Billing Department

Members who email or fax this form can expect a response within 2 business days.

By Mail: **OneShare Health**
Attention: Billing Department
P.O. BOX 825
Uniontown, OH 44685

Please note that submission of this form via mail could take up to 30 days to process from the date received, and up to 60 days past the Member's next billing date .

OneShare Health, LLC is not an insurance company but a religious health care sharing ministry. For our full disclosures, see www.onesharehealth.com/legal-notices for the most up to date state availability listing.

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