

The Primary Member is the only individual allowed to make changes to a current Membership Program. If you are not the Primary Member please contact Member Support at **(833) 546-4478**.

SECTION 1. PRIMARY MEMBER INFORMATION					
First Name:		M.I.:		Last Name:	
Member ID Number:			Date of Birth:		
Address:				City:	
State:		Zip Code:		Phone Number:	
Email Address:					
Gender:		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Requested Effective Date:	

SECTION 2. REASON FOR CHANGE	
<input type="checkbox"/> Marriage	<input type="checkbox"/> Death
<input type="checkbox"/> Birth or Adoption of Child	<input type="checkbox"/> Financial Reasons
<input type="checkbox"/> Divorce	<input type="checkbox"/> Other (provide reason):

SECTION 3. PROGRAM CHANGE REQUEST											
Which Program are you currently enrolled in?											
Please select a new Program below:											
OneShare Classicsm											
Program Tier:		<input type="checkbox"/> Basic			<input type="checkbox"/> Enhanced			<input type="checkbox"/> Crown			
ISA Amount:		<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$7,500	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$7,500	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$7,500	<input type="checkbox"/> \$10,000	
OneShare Catastrophicsm											
ISA Amount:		<input type="checkbox"/> \$5,000			<input type="checkbox"/> \$10,000						
Maximum Limit Per Incident:		<input type="checkbox"/> \$150,000			<input type="checkbox"/> \$250,000			<input type="checkbox"/> \$500,000			
OneShare Completesm											
*FOR CURRENT COMPLETEsm MEMBERS ONLY											
Program Tier:		<input type="checkbox"/> Basic			<input type="checkbox"/> Enhanced			<input type="checkbox"/> Crown			
ISA Amount (Ind / Fam):		<input type="checkbox"/> \$5,000 / \$15,000	<input type="checkbox"/> \$10,000 / \$30,000	<input type="checkbox"/> \$5,000 / \$15,000	<input type="checkbox"/> \$10,000 / \$30,000	<input type="checkbox"/> \$5,000 / \$15,000	<input type="checkbox"/> \$10,000 / \$30,000				

SECTION 4. DEPENDENT INFORMATION					
Add / Remove Dependent / Spouse below. If the Primary Member is being removed, you must complete a new application to continue services for the remaining family members / Dependents. All Members over the age of 18 must sign this form. Adding or deleting dependents to or from the Membership is not considered a program change.					
*Changes in this section will not reset sharing parameters.					
Dependent Name	Relationship	Gender	Date of Birth	Tobacco / Vape User	Status
1.		<input type="checkbox"/> Male		<input type="checkbox"/> Yes	<input type="checkbox"/> Add
		<input type="checkbox"/> Female		<input type="checkbox"/> No	<input type="checkbox"/> Remove
2.		<input type="checkbox"/> Male		<input type="checkbox"/> Yes	<input type="checkbox"/> Add
		<input type="checkbox"/> Female		<input type="checkbox"/> No	<input type="checkbox"/> Remove
3.		<input type="checkbox"/> Male		<input type="checkbox"/> Yes	<input type="checkbox"/> Add
		<input type="checkbox"/> Female		<input type="checkbox"/> No	<input type="checkbox"/> Remove
4.		<input type="checkbox"/> Male		<input type="checkbox"/> Yes	<input type="checkbox"/> Add
		<input type="checkbox"/> Female		<input type="checkbox"/> No	<input type="checkbox"/> Remove

SECTION 5. MEDICAL QUESTIONS

Since the Effective Date of your current OneShare Health Program, have you or any Member of your family been diagnosed with any of these conditions listed below? **Check all those that apply. This section is not applicable to changes involving Member count only.**

<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	HIV / Aids
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heart By-Pass Surgery	<input type="checkbox"/>	Hyperlipidemia	<input type="checkbox"/>	None
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Diabetes I	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Hypertension / High Blood Pressure		
<input type="checkbox"/>	COPD	<input type="checkbox"/>	Diabetes II	<input type="checkbox"/>	Herniated Disc	<input type="checkbox"/>	Kidney Disease / Failure		
Since your Program Effective Date, are you or could you be pregnant?									<input type="checkbox"/> Yes
									<input type="checkbox"/> No
Since your Program Effective Date, do you or any of your Dependents have or had Cancer at any time?									<input type="checkbox"/> Yes
									<input type="checkbox"/> No
Has your physician recommended advanced procedures, (such as CAT / PET scan, EKG, EEG) for abnormal test results, requiring surgical procedures or hospitalization in the next 6 months for you or your family member?									<input type="checkbox"/> Yes
									<input type="checkbox"/> No

SECTION 6. STATEMENT OF BELIEFS (Must agree to all for change to apply)

Acknowledge each statement below:

<input type="checkbox"/>	We Believe in the authority of Scripture and the sanctity and dignity of every human life created by God with special meaning and purpose. <i>II Timothy 3:16; Psalm 139:13-14</i>
<input type="checkbox"/>	We Believe that every individual has the constitutional and religious right and duty to worship God in freedom. <i>II Corinthians 3:17; U.S. Const. amend. I</i>
<input type="checkbox"/>	We Believe and agree in the biblical and ethical principle of sharing with those who are less fortunate and who experience medical needs. <i>Galatians 6:2</i>
<input type="checkbox"/>	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>I Corinthians 6:19-20</i>
<input type="checkbox"/>	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>I John 5:14; Phillipians 4:6-7</i>

SECTION 7: AGREEMENT (Must agree to all for change to apply)

I understand and agree to the items below:

<input type="checkbox"/>	Within the first 10 Business Days after the Effective Date, a Member can elect to make a Program Change, without an Application Fee, or OneShare health approval. Any additional Program changes within the Program Year will result in an Application Fee of \$125.00. to Within the first 10 Business Days after the Effective Date, a Member can elect to make a Program Change, without an Application Fee, or OneShare health approval. One Program Change is allowed without an application fee per program year. Any additional program changes within the Program year will include an application fee.
<input type="checkbox"/>	Any amount met towards the Program Year ISA will be credited.
<input type="checkbox"/>	Program changes will result in a new Effective Date.
<input type="checkbox"/>	All Program Maximums met will be credited towards the new Program.
<input type="checkbox"/>	Credit for time participating under the original Program will apply towards Waiting Periods.
<input type="checkbox"/>	Pre-Existing Condition terms and limitations will be based upon the original Membership Effective Date.
<input type="checkbox"/>	I understand all other Program information currently in place, such as contribution frequency and payment arrangements, will transfer to and remain in effect for the Program elected on this form.

By signing this form, you authorize OneShare Health to deliver your Program change determination to the email address provided.

Upon completing this form, you affirm that the personal information you provided at the time of enrollment or Program change was true and correct. If you have presented inaccurate information for the purpose of determining eligibility for a Program change, it could affect consideration of Sharing Requests or Eligibility, and OneShare Health reserves the right to terminate Membership. Please refer to your Membership Guidebook for more information.

SECTION 7: AGREEMENT CONTINUED (All Members over the age of 18 must sign this form)	
ACKNOWLEDGMENT AND SIGNATURE	
I have fully read and understand the terms in this change form. As the current Primary Member, I wish to request the above change(s) to my original Program 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

This form requires a physical signature, as digital signatures are not permitted.

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 .

Disclaimers & Legal Notices

OneShare Health, LLC is a health care sharing ministry which brings together people of faith to assist each other by voluntarily sharing medical expenses. As a health care sharing ministry, OneShare Health does not contract with Members to provide or pay for medical care, does not offer insurance, makes no assumptions of risk, and does not promise or guarantee that medical expenses will be paid or shared by the Membership. Unpaid medical bills are always your responsibility.

OneShare strives to create a positive Member experience. However, for those unique situations where Members are concerned or dissatisfied, OneShare Health has created a dispute resolution process that is consistent with our shared biblical beliefs about resolution within our community rather than by civil courts (1 Cor. 6:1-8).

By becoming a Member of OneShare Health, each Member agrees to use the following Dispute Resolution and Appeal process as the exclusive means for resolving all disputes, including legal disputes, and to not file a lawsuit. The Member agrees not to engage in litigation against OneShare Health, its affiliates, nor its employees or directors for any reason related to health care or Membership.

The OneShare Dispute Resolution process is as follows:

- 1. Call OneShare:** Many concerns or questions may be resolved by calling us directly. OneShare strives to provide first class Member service, and we want to know immediately if you are not completely satisfied. Before submitting a written dispute, a Member must first attempt to resolve the issue with the applicable Department within OneShare.
- 2. Written Dispute:** If you have been unable to resolve an issue to your satisfaction by calling OneShare, you may file a written dispute within 60 days after the OneShare determination giving rise to your dispute. Disputes may be submitted in three ways: (1) by completing OneShare's Member Dispute Form and submitting it to Dispute@onesharehealth.com, or (2) by completing the Dispute Form and mailing it to OneShare Health, Attn: Disputes, PO Box 825 Uniontown, OH 44685, or (3) by going online to www.onesharehealth.com/memberdisputes and downloading and submitting the form per the instructions above. Any other method of communication will not be considered a dispute for purposes of this Dispute Resolution and Appeal process. The Dispute Form must be completed in full and incomplete disputes will not be considered. OneShare will confirm receipt of your dispute within 3 business days after submission. If the form is incomplete or more information is needed, OneShare will notify you.
- 3. Appeal:** You may appeal an adverse determination of your written dispute by submitting OneShare's Appeal Form to Appeals@onesharehealth.com, or by mailing the completed Appeal Form to Attn: Appeals, PO Box 825 Uniontown, OH 44685 within 30 days after the determination of your dispute. You must include a written summary of your appeal, state why you disagree with the previous determination, and include any portions of your Member Guideline which may be applicable. You will be able to attach any documents you feel are necessary to provide complete information to the OneShare Appeals Committee. The Appeals Committee will consider your appeal within 45 days after submission. Appeals of Pre-Notification determinations will be expedited.
- 4. Arbitration:** If you are unsatisfied with the decision of the OneShare Health Appeals Committee, the final option is to submit the dispute to Arbitration in accordance with the Arbitration Agreement which each Member signs upon enrollment. You may submit the dispute for arbitration with the Institute for Christian Conciliation (ICC) or the American Arbitration Association (A A A). You will be responsible to bear one-half of the fees of your selected arbitration program (ICC or AAA), and all of your own incidental or legal costs. The arbitration shall be held in Dallas, Texas unless you and OneShare agree to a different location. One arbitrator shall preside over the dispute and shall be selected by mutual agreement between you and OneShare. If the parties cannot agree on an arbitrator, the selected arbitration program (ICC or AAA) will appoint the arbitrator. If you wish to invoke this provision, you must send a written notification to OneShare's Legal Department and submit your arbitration request to:

<https://www.aorhope.org/icc>

or

<https://www.adr.org>

ONESHARE HEALTH, LLC (ONESHARE) IS NOT AN INSURANCE COMPANY BUT A RELIGIOUS HEALTH CARE SHARING MINISTRY (HCSM) THAT FACILITATES THE SHARING OF MEDICAL EXPENSES AMONG MEMBERS. As with all HCSMs under 26 USC § 5000A(d)(2)(B)(ii), OneShare's Members are exempt from the ACA individual mandate. OneShare does not assume any legal risk or obligation for payment of Member medical expenses. Neither OneShare nor its Members guarantee or promise that medical bills will be paid or shared by the Membership. Available nationwide, but please check www.onesharehealth.com/legal-notices for the most up to date state availability listing.

*Rates will vary based on state, Member's age, Demographics, Program, and Tier.

**Does not include Washington Catastrophic Program Members, services may vary by state.