

Only the Primary Member may make changes to a Membership. If you are not the Primary Member, please contact Member Support at (833) 546-4478.

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:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Requested Effective Date:
Only complete the remainder of this Section if changing your contact information			
Address:		City:	
State:	Zip Code:	Phone Number:	
Email Address:			

SECTION 2. REASON FOR DEMOGRAPHIC CHANGE (select all that apply)			
<input type="checkbox"/> Marriage	<input type="checkbox"/> Death	<input type="checkbox"/> Birth or Adoption of Child	
<input type="checkbox"/> 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 (833) 546-4478 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.		<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 4: AGREEMENT (Must agree to all for change to apply)	
I understand and agree to the items below:	
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.

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

If you are not making any Program changes, proceed to Page 3.

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:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Requested Effective Date:

SECTION 2. REASON FOR PROGRAM CHANGE (select all that apply)			
<input type="checkbox"/>	New Medical Condition	<input type="checkbox"/>	Financial Reasons
<input type="checkbox"/>	We are Trying to Get Pregnant		
<input type="checkbox"/>	Other (provide reason):		
<input type="checkbox"/>	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 Classicsm											
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 Catastrophicsm											
ISA Amount		\$5,000			\$10,000						
Maximum Limit Per Incident		\$150,000			\$250,000			\$500,000			
Level: OneShare Completesm											
*FOR CURRENT COMPLETEsm 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.						
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	Anorexia	
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heart By-Pass Surgery	
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Diabetes I	<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	COPD	<input type="checkbox"/>	Diabetes II	<input type="checkbox"/>	Herniated Disc	
<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	HIV / Aids	<input type="checkbox"/>	None	
<input type="checkbox"/>	Hyperlipidemia				<input type="checkbox"/>	Hypertension / High Blood Pressure
<input type="checkbox"/>	Kidney Disease / Failure				<input type="checkbox"/>	
Since your initial Program Active Date, are you or any Dependent or Spouse on the Membership pregnant, or could be pregnant?					<input type="checkbox"/>	Yes
					<input type="checkbox"/>	No
Since your initial Program Active Date, have you or any Dependent or Spouse on the Membership had Cancer at any time?					<input type="checkbox"/>	Yes
					<input type="checkbox"/>	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?					<input type="checkbox"/>	Yes
					<input type="checkbox"/>	No

SECTION 5: AGREEMENT (Must agree to all for change to apply)	
I understand and agree to the items below:	
<input type="checkbox"/>	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.
<input type="checkbox"/>	Any amount already met towards my Program Year ISA or Program Maximums will be credited.
<input type="checkbox"/>	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).
<input type="checkbox"/>	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.

PAGE 3: Statement of Beliefs and Signature

SECTION 1. 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; Philippians 4:6-7</i>

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-notice for the most up to date state availability listing.