

## Member Application

Member Information										
Last Name:		First Name:			MI:	DOB:		Female	Male	
Language:			Street Address:							
City:		State:			Zip Code:		SSN #:			
Email Address:					Authorized to email?		Yes	No		
Phone:		Cell	Home	Work	Phone:		Cell	Home	Work	

Membership Plans						
Please select your plan* (For plan choices and complete plan descriptions, please visit <a href="http://www.alierahealthcare.com">www.alierahealthcare.com</a> )						
<i>*Note: Enrollment must be completed before the 15th of the month before desired effective date AND the first month's premiums received. Coverage cannot be back-dated.</i>						
<b>AlieraCare</b>	Value		5,000 MSRA			
	Plus		7,500 MSRA			
	Premium		10,000 MSRA			
<b>CarePlus</b>	150,000 Catastrophic Sharing Limit		5,000 MSRA			
	250,000 Catastrophic Sharing Limit					
	500,000 Catastrophic Sharing Limit		10,000 MSRA			
<b>InterimCare</b>	Per Term	0-30 Days		Value	1,500 MSRA	
		31-180 Days		Plus	2,500 MSRA	
	Per Incident	181-364 Days		Premium	5,000 MSRA	
					10,000 MSRA	
<b>Unity HealthShare Bronze   Silver   Gold</b>	Bronze		1,000 MSRA			
	Silver		2,500 MSRA			
			5,000 MSRA			
	Gold		10,000 MSRA			
<b>Prima Care &amp; PrimaCare Senior</b>	PrimaCare		Standard			
	PrimaCare Senior		Premium			
Type of plan:	New	Modified	Reinstatement ID #		Desired Effective Date:	

Dependent Information				
If dependent has a different mailing address, please provide name and address on a separate piece of paper and attach here.*				
1. Relationship to Member:				
Last Name:		First Name:		MI
DOB:	SSN:	Male	Female	
2. Relationship to Member:				
Last Name:		First Name:		MI
DOB:	SSN:	Male	Female	
3. Relationship to Member:				
Last Name:		First Name:		MI
DOB:	SSN:	Male	Female	
4. Relationship to Member:				
Last Name:		First Name:		MI
DOB:	SSN:	Male	Female	

## Authorization

### Terms and Conditions

- I acknowledge and understand that I am voluntarily becoming an Alieria Healthcare, Inc. ("AHI") member and that this agreement is non-transferable.
- I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance.
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of Alieria including but not limited to emergency room, hospital and specialty services and that Alieria will not bill insurance carriers for any services provided by Alieria.
- I acknowledge and understand that Alieria must maintain a record of my health information and must protect the privacy of my health information as per the terms of the Notice of Privacy Practices. I understand and acknowledge that this policy is available for my review at any time at [www.Alieriahealthcare.com](http://www.Alieriahealthcare.com) or upon request.
- I acknowledge and understand that I may terminate this Member Agreement at any time and for any or for no reason by providing written notice to Alieria. Monthly fees will continue to accrue until written termination notice is received. Any pre-paid monthly care fees will be prorated to the date Alieria has received the written termination and refunded within ten (10) business days.
- In addition, I acknowledge and understand that Alieria may terminate this Member Agreement by providing me written notice and any pre-paid monthly care fees will be prorated to the date of termination and refunded to me within ten (10) business days. Alieria will not terminate this Member Agreement solely based on health status.
- I acknowledge and understand that Alieria may add or discontinue services or may increase my fee schedule at any time (but no more than once per year), and that I will be given, in writing, at least thirty (30) days' notice of such fee schedule changes.
- I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the Medicare Opt-out Agreement for review and signature before my first appointment. (The Opt-out Agreement does not prevent me from receiving current or future Medicare benefits from non-Alieria providers; neither I nor my Alieria healthcare provider(s) will seek reimbursement from Medicare for the medical services I receive from Alieria.)

### Rights & Responsibilities

- I understand that I have the right to choose my personal health care clinician and to change my clinician at any time, for any reason. I understand that all reasonable efforts will be made to accommodate my request, but only if my new clinician's patient panel is open to new patients.
- I understand that I have the right to receive accurate and easily understood information about Alieria's health care services, health care professionals and health care facilities. If I speak a language different from my clinician, have a physical or mental disability or do not understand something, I understand that Alieria will make its best effort to aid so I can make informed health care decisions. If I require interpreter services beyond what can be provided by Alieria, professional interpreters may be provided at an additional cost to me.
- In the event of membership termination, I understand that I must complete a written Service Cancellation Form. Any differences in payment between my billing date and the date of cancellation will be refunded to me via the payment method I have chosen for my monthly care fee. I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my Alieria healthcare participating clinician(s). I also understand that I am responsible for communicating clearly and respectfully with my clinician and Alieria participating medical team and staff members. Should I become dissatisfied with my care or Alieria services, I agree to notify Alieria immediately so my concerns may be addressed in a timely manner.
- I understand that I have the right to know all my treatment options and to participate in my health care decisions. Parents, guardians, family members or other individuals whom I designate may represent me if I cannot make my own decisions.
- I understand that I have the right to speak in confidence with my Alieria participating provider(s) and to have my health care information protected. I understand that Alieria will not disclose my information without my authorization or without a legal obligation to do so. I also understand that I have the right to review and receive a copy of my personal medical record and may request that my health care provider(s) amend my record if I feel it is inaccurate or incomplete by contacting the Alieria HIM Department.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care clinician(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of health care services and facilities. I agree to first bring any complaints to the attention of Alieria staff and to participate in the Alieria complaint and grievance process.
- To receive the best possible care, I agree to be actively involved in my health care decisions and to disclose all relevant information to my Alieria health care clinician(s) so that they can help me achieve my health goals. I also agree to inform my Alieria health care clinician(s) of any healthcare services I receive outside of Alieria (such as emergency room, specialist, or hospital services).
- I understand that I am responsible for not exposing myself or others to disease or danger. I understand that I can receive information from my Alieria health care clinician(s) about protecting the health and safety of myself and others.

**Authorization cont.****HCSM Programs - Unity HealthShare (UHS) Statement of Beliefs**

At the core of what Unity HealthShare does, and how it relates to and engages with one another as a community of people, is a set of common beliefs.

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when he/she is in need according to our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare, in consultation with physicians, family or other valued advisors.

**Cost Sharing Understanding**

Unity HealthShare, a registered DBA, is a faith-based medical need sharing membership. Medical needs are only shared in by members per the membership guidelines. This application or membership is not issued by an insurance company, nor is it offered through an insurance company. This membership does not guarantee or promise that the eligible medical needs will be shared by the membership. This membership should never be considered as a substitute for an insurance policy.

- I understand that the membership is not insurance but is a voluntary medical needs sharing ministry, and that there are no representations, promises, or guarantees that my medical needs will be shared on my behalf. I also understand that sharing for medical needs does not come from an insurance company, but from the membership per the guidelines and membership Escrow Instructions. I also understand that any medical condition that is inquired about but not disclosed on this application, whether meeting the definition of a pre-existing condition or not, and then discovered after my membership is effective will be treated as if it had been disclosed at the time of application by applying the governing standards set forth in the Membership Eligibility Manual retroactively to my effective date of membership.
- I understand that the guidelines in effect on the date of medical services supersede any spoken or verbal communication and all previous versions of the guidelines. I also understand that with notice to the general membership the guidelines may change at any time based on the preferences of the membership, and decisions, recommendations and approval of the Board of Trustees.
- I understand that the guidelines are not a contract and do not constitute a promise or obligation to share, but instead are for UHS' reference in following the Membership Escrow Instructions. I also understand that the guidelines are part of and incorporated into this UHS Application as if appended to it.
- I understand that each child must be a dependent to participate on their parent's membership. I also understand that eligibility for the membership for anyone, a dependent or otherwise, is based on the guidelines and that continued submission of monthly contributions does not extend an ineligible participant's membership.
- I understand that there is a one-time application fee of \$125. The application fee of \$100 will be refunded automatically if all individuals on my application are declined for membership or if I withdraw my application prior to my membership effective date. I also understand that the application fee will not be refunded if, in the course of applying for membership, I fail to respond to written or verbal inquiries from UHS for more than sixty days. I also understand that the \$25 donation portion of the application fee to UHS Ministries is non-refundable.
- I understand that monthly contribution amounts are based on operating and medical needs and the total number of members and that monthly contributions are figured on a periodic basis as needed and are subject to change at any time. I also understand that the submission of my monthly contributions is voluntary and that I am not obligated in any way to send any money.

**Notice:** This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

**By my signature below, I agree to become an Alieria member and I agree to the terms and conditions outlines in this Member Agreement and Disclosure.**

Signature:

Printed Name:

Date:

SIGNATURE BY:

Member

Parent

Legal Guardian

**Payment Options**

Payment:	Credit Card	ACH	Total Member Fee \$ (Drafted on a recurring basis)	Total Enrollment Fee \$ (One-time fee)
----------	-------------	-----	---	---

**Credit Card**

Name on Card:	Card Type:	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover
Card Number:	Exp:	CVC:
Card Billing Address:		

**ACH** (Please attach a voided company check to this form)

Bank Name:	Account Type:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Name on Account:	Account Number:	Routing Number:

**The following authorization applies only to Individual Member plans. Members who are part of Employer based groups enjoying AHI services are covered by the terms, conditions, and authorizations of the Employer group contract. See your Employer for all details.**

*By signing below, I hereby authorize AHI and UHS to contact me using the information I have provided via on-line enrollment. Further, I hereby authorize AHI and UHS, in accordance with each program's corresponding charge requirements, to initiate charges to my credit card, debit card or bank account for my initial and recurring fees and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the separate transaction amounts for each plan represent the total of my plan fee plus the separate plan fees of any dependents on my account. This approval is given regardless if the agreement submitted is in my name, the name of the Primary Member listed herein, or the name of one of the dependents listed under the Primary Member. I understand that the plan fees charged to my credit card will be accurately reflected as those shown on the plans or the most recent fees change via notifications issued to the Primary Member (the subscriber) by AHI or UHS. This authorization is valid until such time I provide to AHI or UHS a 30-day written notification of cancellation of these plans.*

- *This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until AHI or UHS has received written notification from me of either plan's termination in such time and in such manner as to afford AHI or UHS and their financial institution a reasonable opportunity to act on it.*
- *I understand that my participation in AHI and UHS is continuous and that, by signing below, I authorize recurring credit/debit card charges for the individual listed.*
- *I understand that a \$25 fee will be charged to me for declined credit or debit card transactions, including recurring transactions, that are not honored.*
- *I understand this is a month-to-month program and further understand that a \$75.00 (\$50 AHI/\$25 UHS) renewal fee will be charged on the thirteenth month and every thirteenth month thereafter in which the Plan is in effect.*

Signature:	Printed Name:
Date:	

## Health Assessment and Attestation

### Member Information

Please take a few minutes to answer the following questions. The information will be reviewed by Unity only for consideration of your membership application.

Last Name:			First Name:			MI:	Date of Birth:
Sex:	<input type="checkbox"/> Female	<input type="checkbox"/> Male	Member ID:	Today's Date:			
Street Address:							
City:				State:		Zip Code:	

1. Check each item you currently have, or you have had in the past 24 months

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Measles	<input type="checkbox"/> Weight change
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mumps	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tumor/cancer	<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Liver disease/Hepatitis
<input type="checkbox"/> Heart Bypass Surgery	<input type="checkbox"/> Anemia	<input type="checkbox"/> Broken bones
<input type="checkbox"/> Depression	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Bone or joint problems
<input type="checkbox"/> Diabetes Type I	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Immune suppression
<input type="checkbox"/> Diabetes Type II	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Knee pain/injury
<input type="checkbox"/> Chronic Heartburn/GERD	<input type="checkbox"/> Gout	<input type="checkbox"/> Foot pain/injury
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Neck pain/injury
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding or blood disorder	<input type="checkbox"/> Loss of limb
<input type="checkbox"/> Irritable Bowel Disease	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Severe headaches
<input type="checkbox"/> Lower Back or Neck Pain	<input type="checkbox"/> Stroke or paralysis	<input type="checkbox"/> Dizziness or fainting
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Epilepsy or seizures
<input type="checkbox"/> Chicken Pox or Shingles	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Stomach or intestinal problem	<input type="checkbox"/> Chronic or recurrent infection	<input type="checkbox"/> Severe weakness or tiredness
<input type="checkbox"/> Emotional or psychiatric problems	<input type="checkbox"/> Palpitations or irregular heart beat	<input type="checkbox"/> Tuberculosis or positive TB skin test
<input type="checkbox"/> Drugs or alcohol dependency	<input type="checkbox"/> Numbness or tingling of legs or feet	<input type="checkbox"/> Hearing loss or ear problems
<input type="checkbox"/> Shoulder/elbow/wrist/hand pain	<input type="checkbox"/> Numbness or tingling of arms or hands	<input type="checkbox"/> Skin problems or chronic rash

2. Please list all other health concerns that you have:

3. What is your weight? What is your height?

4. Do you smoke?  Yes  No

If yes, how often?

5. Do you currently have or have ever had cancer?  Yes  No

If yes, how long ago:

6. Do you play competitive sports?  Yes  No

If yes, please list all competitive sports in which you participate:

7. Do you drink excessively?  Yes  No

If yes, what is your weekly intake:

8. Are you pregnant?  Yes  No

Members must agree to the following Unity HealthShare **Statement of Beliefs** to qualify:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need, according to our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors, or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare, in consultation with physicians, family, or other valued advisors.

Do you agree with this Statement of Beliefs?

Yes

No

Signature:

Printed Name:

Date: