ALIERA Healthcare

Member Application-Individual

Members

Last Name	First Name	MI	Language			Date of Birth
				◯ Male	◯ Female	

Street Address	City	State	Zip

Email Address	Authorized to email?	SSN #
	◯ Yes ◯ No	

Phone	Phone
◯ Cell ◯ Home ◯ Work	◯ Cell ◯ Home ◯ Work

Membership Plans

Please select your plan* (For plan choices and complete plan descriptions, please visit www.alierahealthcare.com)

**Note: Enrollment must be completed before the 15th of the month before the effective date AND the first month's premiums received. Coverage cannot be back-dated.*

AlieraCare	◯ Value ◯ Plus ◯ Premium		◯ 5000 MSRA ◯ 7500 MSRA ◯ 10000 MSRA	
CarePlus	◯ 150,000 Catastrophic Sharing Limit ◯ 250,000 Catastrophic Sharing Limit ◯ 500,000 Catastrophic Sharing Limit		◯ 5000 MSRA ◯ 1000 MSRA	
InterimCare	◯ Per Term ◯ Per Incident	◯ 0-30 Days ◯ 31-180 Days ◯ 181-364 Days	◯ Value ◯ Plus ◯ Premium	◯ 1500 MSRA ◯ 2500 MSRA ◯ 5000 MSRA ◯ 10000 MSRA
Unity HealthShare Bronze | Silver | Gold	◯ Bronze ◯ Silver ◯ Gold		◯ 1500 MSRA ◯ 2500 MSRA ◯ 5000 MSRA ◯ 10000 MSRA	
PrimaCare & PrimaCare Senior	◯ PrimaCare ◯ PrimaCare Senior		◯ Standard ◯ 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:			SSN #	
Last Name	First Name	MI	◯ Male	◯ Female	Date of Birth
2.	Relationship to Member:			SSN #	
Last Name	First Name	MI	◯ Male	◯ Female	Date of Birth
3.	Relationship to Member:			SSN #	
Last Name	First Name	MI	◯ Male	◯ Female	Date of Birth
4.	Relationship to Member:			SSN #	
Last Name	First Name	MI	◯ Male	◯ Female	Date of Birth

Authorization

Terms and Conditions - Aliera Healthcare, Inc. (AHI)

- I acknowledge and understand that I am voluntarily becoming a Aliera Healthcare 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 Aliera including but not limited to emergency room, hospital and specialty services and that Aliera will not bill insurance carriers for any services provided by Aliera.
- I acknowledge and understand that Aliera 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.Alierahealthcare.com or upon request.
- I acknowledge and agree to pre-pay my monthly care fee on or before its due date for the upcoming month. If I am unable to pay my fee(s) on time, I understand that I will be charged a $25 late fee initially and $25 per month thereafter and agree to owe the total late fee balance along with all past due monthly care fees and acknowledge that my service agreement may be terminated.
- 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 Aliera. Monthly fees will continue to accrue until written termination notice is received. Any pre-paid monthly care fees will be prorated to the date Aliera has received the written termination and refunded within ten (10) business days.
- In addition, I acknowledge and understand that Aliera 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. Aliera will not terminate this Member Agreement solely based on health status.
- I acknowledge and understand that Aliera 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 sixty (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-Aliera providers; neither I nor my Aliera healthcare provider(s) will seek reimbursement from Medicare for the medical services I receive from Aliera.)

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 Aliera'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 Aliera 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 Aliera, 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 Aliera healthcare participating clinician (s). I also understand that I am responsible for communicating clearly and respectfully with my clinician and Aliera participating medical team and staff members. Should I become dissatisfied with my care or Aliera services, I agree to notify Aliera 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 Aliera participating provider(s) and to have my health care information protected. I understand that Aliera 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 Aliera 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 Aliera staff and to participate in the Aliera 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 Aliera health care clinician(s) so that they can help me achieve my health goals. I also agree to inform my Aliera health care clinician(s) of any healthcare services I receive outside of Aliera (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 Aliera health care clinician(s) about protecting the health and safety of myself and others.

HCSM Programs - Unity HealthShare (UHS) Statement of Benefits

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. UHS' Statement of Beliefs are as follows:

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.

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 the members according to 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 according to 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 the $125 application fee 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 Aliera member and I agree to the terms and conditions outlines in this Member Agreement and Disclosure.

Signature	***Please Print Full 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	Card Type: ◯ Visa ◯ MasterCard ◯ Discover	
Name on Card:	Card Number:	Exp:
Card billing address:		CVC:

ACH (Please attach a voided company check to this form)	Bank name:	Account Type: ◯ Checking ◯ 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/HP USA 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/HPUSA and UHS to contact me using the information I have provided via on-line enrollment. Further, I hereby authorize AHI/HPUSA 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/HPUSA or UHS. This authorization is valid until such time I provide to AHI/HPUSA 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/HPUSA or UHS has received written notification from me of either plan's termination in such time and in such manner as to afford AHI/HPUSA or UHS and their financial institution a reasonable opportunity to act on it.*
- *I understand that my participation in AHI/HPUSA 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	***Date***

This is NOT Insurance

Health Assessment & Attestation

Please take a few minutes to answer the following questions.

The information will be reviewed by Unity HealthShare only for consideration of your membership application.

Name:	DOB:	Phone:	
Street Address:	City:	State:	Zip:

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

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

2. Please list all other health concerns you have:

   _____

   _____

3. What is your weight? _____ What is your height? _____
4. Do you smoke? ◯ Yes ◯ No

   If yes, how much: _____
5. Do you currently have or ever had cancer? ◯ Yes ◯ No

   If yes, how long ago: _____

6. Do you play competitive sports? ◯ Yes ◯ No

   If yes, please list all competetive 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**

You acknowledge the first two months of contribution will be used as administration fees. ◯ **Yes** ◯ **No**

Signature: _____ ***Date***: _____