Member Application

You also can apply online at www.pohealthcare.com

How did you hear about us? ☐ Agent ☐ Member ☐ Friend ☐ Other Name :

People participating at this time? ☐ Applicant Only ☐ Applicant & Spouse ☐ Family ☐ Applicant & Children

Membership Type

Applicant	☐ Platinum	☐ Gold	☐ Bronze
Spouse	☐ Platinum	☐ Gold	☐ Bronze
Dependent	☐ Platinum	☐ Gold	☐ Bronze

Applicant Information

Last Name | First Name | Middle Name

Date of Birth (MM / DD / YYYY) | Social Security # (XXX-XX-XXXX) | Gender ☐ M ☐ F

Address | APT#

City | ST. | ZIP

☎ Cell (XXX-XXX-XXXX) | ☎ Home (XXX-XXX-XXXX)

Email Address

Spouse Information

Last Name | First Name | Middle Name

Date of Birth (MM / DD / YYYY) | Social Security # (XXX-XX-XXXX) | Gender ☐ M ☐ F

☎ Cell (XXX-XXX-XXXX) | ☎ Home (XXX-XXX-XXXX)

Dependent Information

Last Name | First Name | Middle Name

Date of Birth (MM / DD / YYYY) | Social Security # (XXX-XX-XXXX) | Gender ☐ M ☐ F

Last Name | First Name | Middle Name

Date of Birth (MM / DD / YYYY) | Social Security # (XXX-XX-XXXX) | Gender ☐ M ☐ F

Last Name | First Name | Middle Name

Date of Birth (MM / DD / YYYY) | Social Security # (XXX-XX-XXXX) | Gender ☐ M ☐ F

Additional dependent, please list on additional sheet.

Bank Information

Account Type: Checking / Saving | Bank Name

Routing number | Account number

☐ I authorize Altrua HealthSare to make automatic withdrawals from the account for the amount of my monthly contribution.
Note: An additional ACH authorization form may be needed by financial institute

Medical History Questionnaire

1. Do you (or any applicant in your family) currently have any of the following conditions?
   - ☐ Alzheimer's Disease
   - ☐ Autism Disorders
   - ☐ Diabetes Type I
   - ☐ Cystic Fibrosis
   - ☐ Down's Syndrome
   - ☐ Fragile X Syndrome
   - ☐ Sickle-Cell Disease
   - ☐ Cancer
   - ☐ Cerebral Palsy
   - ☐ Emphysema
   - ☐ Spina Bifida
   - ☐ Muscular Dystrophy
   - ☐ Parkinson's Disease
   - ☐ Chronic Kidney Disease
   - ☐ Cholera
   - ☐ Dementia
   - ☐ HIV/AIDS
   - ☐ Typhoid
   - ☐ Lyme's Disease
   - ☐ Schizophrenia, Paranoia, or Psychosis
   - ☐ Chronic Obstructive Pulmonary Disease
   - ☐ Hepatitis (Chronic Viral B & C)
   - ☐ None of the above
2. Have you (or any applicants) been diagnosed with any of the below within the last 10 years?
   - ☐ Auto Immune Disease
   - ☐ Migraines
   - ☐ Skin Condition or Disease
   - ☐ Endocrine or Metabolic Disorder
   - ☐ Infectious or Parasitic Disease
   - ☐ Type II Diabetes
   - ☐ Cancer
   - ☐ Nutritional deficiency
   - ☐ Eye condition or Disease
   - ☐ Respiratory condition or Disease
   - ☐ Disease or Condition relating to the nervous system or sense organs
   - ☐ Condition or Disease of the circulatory system
   - ☐ Condition or Disease of the Musculoskeletal System
   - ☐ Condition or Disease relating to the reproductive or urinary systems
   - ☐ Digestive system condition or Disease
   - ☐ Tumor or Abnormal benign growth
   - ☐ None of the above
3. Have you (or any applicant in your family) used illegal drugs within the last 12 months? ☐ Yes ☐ No
4. Have you (or any applicant in your family) used tobacco or nicotine related products (i.e. vapor, e-cigarettes, chewing tobacco, cigars) within the last 12 months? ☐ Yes ☐ No
5. Is anyone applying currently pregnant or suspect they may be? ☐ Yes ☐ No
6. Do you (or any applicants) currently undergo immunotherapy treatment for allergies? ☐ Yes ☐ No
7. Have you (or any applicant in your family) been diagnosed with a mental illness or condition (i.e. depression, anxiety, bi-polar disorder)? ☐ Yes ☐ No
8. Do you (or any applicant) currently have an implant/hardware, prosthesis, or monitoring device? If so, which type? ☐ Yes ☐ No
9. Have you (or any applicant) had a surgical operation within the last 10 years? Please do not include tonsil removal, adenoid removal, gallbladder removal, or appendix removal or any surgeries related to a cancer diagnosis? ☐ Yes ☐ No

If you answered "YES" to any question in the Medical History Questionnaire, explain further below (More information using the attached Explanation page.)

Question Number	Conditions, Injury, Symptom or Diagnosis		
	Date it started	Date of recovery (if applicable)	Was recovery complete?
	MM / DD / YYYY	MM / DD / YYYY	
Person affected		What is it?	
Types of Treatment Given, and Medications Prescribed			

ACKNOWLEDGMENTS

I understand that the Altrua HealthShare membership is not insurance but is a voluntary medical expense sharing program, and that there are no representations, promises, or guarantees that my medical needs will be shared. I also understand that the contributions for medical needs do not come from an insurance company, but from the membership according to the membership guidelines and Escrow Instructions.

I understand that acceptance into the membership is not an entitlement but a privilege based, in part, on the medical history information I provide in this application. 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 failure to uphold my commitments (shown under COMMITMENTS on this page) and to abide by the Statement of Standards may result in my membership becoming inactive and ineligibility of my medical needs. 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 pay, but instead are for Altrua HealthShare's reference in following the membership Escrow Instructions. I also understand that the guidelines are part of and incorporated into this Altrua HealthShare 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 payment of monthly contributions does not extend an ineligible participant's membership.

I understand that monthly contributions 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 payment of my monthly contributions is voluntary and that I am not obligated in any way to send any money. I also understand that if I receive monthly contributions for my medical needs, my name and address will be reported to the contributor of those monthly contributions.

I understand that the Program does not pre-authorize medical procedures or treatment and that verification of eligible medical needs occurs only after charges are incurred.

MEMBER STATEMENT

I agree to live a clean and healthy lifestyle and share the following ethical or religious beliefs:

› We care for one another.
› We keep our bodies clean and healthy with proper nutrition.
› We believe the use of any form of tobacco, illicit drugs and excessive alcohol consumption is harmful to the body and soul.
› We believe sexual relations outside the bond of marriage is contrary to the teachings of the Bible and that marriage should be held in honor.
› We believe abortion is wrong, except in a life-threatening situation to the mother.
› We care for our families and physical, mental or emotional abuse of any kind to a family member or anyone else is morally wrong.

COMMITMENTS

I have read and understand the membership guidelines and accept them as the governing document for determining eligibility of my, or anyone else's medical needs submitted to Altrua HealthShare.

I further agree to hold GAP Healthcare and its trustees, officers, employees, representatives and service providers harmless, and to limit any dispute I may have over the eligibility of my, or anyone else's medical needs to the appeal procedure described in the guidelines.

So as not to take advantage of my fellow members, I have answered all questions in this application in good faith, truthfully, completely and accurately.

In recognition of the voluntary nature of the membership, I hereby promise that in the event of a disagreement over the payment of my or anyone else's medical needs, my dependents and I will bring no legal claim, demand or suit of any kind for unpaid medical expenses, but will follow the appeal and mandatory mediation procedure described in the guidelines. I and my dependents also accept and appoint Altrua HealthShare as the final authority on the interpretation of the guidelines and, agree to indemnify and hold harmless Altrua HealthShare and its trustees, officers, employees, representatives and service providers from any damages or expenses, including legal fees, arising from any breach of these promises, from any failure to follow the guidelines, or from any failure to provide accurate, complete and honest information to Altrua HealthShare.

MEMBERSHIP ESCROW INSTRUCTIONS

I, the membership participant, direct Altrua HealthShare to hold in escrow, as escrow agent, all membership monthly contributions that I deliver to Altrua HealthShare and then to distribute all monthly contributions pursuant to the following escrow instructions and in the following order:

(1) First, to pay the expenses of operating the membership, including all of Altrua HealthShare's expenses necessary to provide for the continued viability of the membership;
(2) then, to pay eligible needs pursuant to the guidelines as modified from time to time by Altrua HealthShare and as interpreted and applied by Altrua HealthShare;
(3) then, in the event the membership is to be terminated, and after Altrua HealthShare determines that the funds held in escrow are sufficient to pay for the items listed above, any remaining funds shall be disbursed to qualified charities, as determined by Altrua HealthShare. Altrua HealthShare must report to me who my monthly contributions are given to, if requested.

Altrua HealthShare may deposit or otherwise hold the escrowed contributions in one or more common bank accounts with escrowed contributions from other membership participants, until they are distributed pursuant to these instructions. Interest or other earnings on the escrowed monthly contributions shall become escrowed monthly contributions and shall be held and disbursed pursuant to these instructions. Altrua HealthShare shall not be obligated to invest the escrowed monthly contributions, provided, however, that if the escrowed monthly contributions are invested, Altrua HealthShare shall not be liable for substandard returns or for losses. Also, as a condition of receiving and distributing my monthly contributions Altrua HealthShare must report to me who my monthly contributions are given to, if requested.

This escrow arrangement does not create any rights in or benefits for membership participants or third parties to any escrowed monthly contributions.

SIGNATURE

I/we hereby authorize the release of any requested medical information to Altrua HealthShare for the purpose of determining eligibility for acceptance into the Healthcare program for myself and any listed family members. This authorization will be valid for 90 days following the date indicated below.

With my signature below, I hereby verify each of the following:

(1) That I am aware of and understand each item under ACKNOWLEDGMENTS.
(2) That I live according to each item under the MEMBER STATEMENT.
(3) That I commit to each item under COMMITMENTS.
(4) That I issue the ESCROW INSTRUCTIONS to GAP Healthcare.
(5) That I have provided a true and accurate medical history in this application as directed on the Medical History Questionnaire and Medical History Explanation pages.
(6) I hereby authorize and permit true copies or facsimiles of this original application to be used in its place.

Signature of Applicant **Date**