APPLICATION PROCESS FOR NEW APPLICANTS

1. New Applicant fills out Member Application and Medical Questionnaires* in its entirety for themselves or family.
   (All pages must be completed along with all medical information listed on page 3 of application.)
2. New Applicant submits their Application* along with fees** to Altrua HealthShare.
   (May be submitted online, scanned and emailed or printed and mailed.)
3. Once Altrua HealthShare receives the Application* and fees, New Applicant will be contacted by phone or email to confirm receipt of Application.
4. New Applications will go through the approval process pending test results, limitations, etc.
5. If the New Applicant decides to withdraw their application they must contact Altrua Health Share directly.
6. If the New Applicant has membership limitations that apply, New Applicant must sign the membership limitations document prior to membership being effective.
7. If New Applicant accepts terms of membership, New Applicant will be contacted by phone or email advising them of their acceptance and effective date.
8. A New Member Welcome Packet will be mailed to the address of the New Member.
9. Membership ID cards will be mailed separately to New Member once completed.
10. For any questions regarding a New Membership:
    www.okhcex.com, *(see FAQ's or Member Guidelines)*
    Email: help@okhcex.com Call: (855) 786-8343

---

* Please make sure if you're 40 or older, you have included the proper test results requested

** Payment Options: Online ACH, Online Credit Card, traditional check

---

APPLICATION
For Membership

Carry each others burdens and in this way you will fulfill the law of Christ. Galations 6:2

Altrua HealthShare ...caring for one another

Refer to the Altrua HealthShare membership guidelines for the definitions of the underlined terms that are used throughout the application. If you do not have a copy of the guidelines, contact Altrua HealthShare. Please print or type in black ink. Incomplete applications cannot be processed.

Name (Last, First, Middle) (When a man is applying with his wife and/or children, his name must go here)					
Birthdate (Month/Day/Year)		Height	Weight		Sex
Street Address or P.O. Box		City		State	Zip
Social Security Number	Employer	Occupation/Title			
Home Phone	Work Phone	E-mail			

Is each person on the application a U.S. citizen? ☐ Yes ☐ No If no, how long in the U.S. ____________

Is each child a dependent of both parents? ☐ Yes ☐ No ☐ Not applicable

If one or more family member(s) is ineligible for membership, would the rest of the family still like to join? ☐ Yes ☐ No ☐ Not applicable

Please choose your membership type:
(See Membership Guidelines and Monthly Contribution Table)

Standard ☐ Gold ☐ Silver ☐ Bronze

Advantage ☐ Gold ☐ Silver ☐ Bronze

How did you hear about us?

Referral ☐ Referred by: ____________ Advertisement ☐ ____________ Other ☐ ____________

If spouse and children are applying for the membership, list their names and information here:

Spouse Name (Last, First, Middle)					
Birthdate (Month/Day/Year)		Height	Weight		Sex
Street Address or P.O. Box		City		State	Zip
Social Security Number	Employer	Occupation/Title			
Child Name (Last, First, Middle)		Social Security Number			
Birthdate (Month/Day/Year)		Height	Weight		Sex
Child Name (Last, First, Middle)		Social Security Number			
Birthdate (Month/Day/Year)		Height	Weight		Sex
Child Name (Last, First, Middle)		Social Security Number			
Birthdate (Month/Day/Year)		Height	Weight		Sex
Child Name (Last, First, Middle)		Social Security Number			
Birthdate (Month/Day/Year)		Height	Weight		Sex
Child Name (Last, First, Middle)		Social Security Number			
Birthdate (Month/Day/Year)		Height	Weight		Sex
Child Name (Last, First, Middle)		Social Security Number			
Birthdate (Month/Day/Year)		Height	Weight		Sex

Altrua HealthShare

MEDICAL HISTORY QUESTIONNAIRE

APPLICATION

INSTRUCTIONS: Answer each question for every person applying, including children, and for the entire time period specified. Examples given (e.g.) are for illustrative purposes only and are not all inclusive. Any past or present symptoms significant enough to mention to a physician must be noted on the application. Upon discovery, inaccurate or untruthful responses may result in a retro-active exclusion of a condition or a retro-active denial of an applicant. "YES" answers will not necessarily cause an applicant to be rejected, but will require further information on the Medical History Explanation page.

I. CURRENT MEDICAL STATUS

A. Is anyone applying currently pregnant, suspect they are, or did anyone applying deliver in the last 30 days? ☐YES ☐NO

B. Is there any medical treatment currently pending or planned? ☐YES ☐NO

C. Does anyone applying currently have any disabilities or handicaps? (e.g., physical, mental or learning) ☐YES ☐NO

D. Is anyone applying currently taking any prescription medications? ☐YES ☐NO

II. 3-YEAR MEDICAL HISTORY

A. In the last 3 years, has anyone applying had any other symptoms, medication, treatment, hospitalization, illness or injury? ☐YES ☐NO

III. 10-YEAR MEDICAL HISTORY - In the last 10 years, has anyone applying been treated for or had tests, diagnosis or symptoms for or pertaining to the following:

A. Infections or parasitic diseases? (e.g., cholera, typhoid, hepatitis, venereal disease, or any other disease caused by bacteria, virus, parasites or fungus or associated with any other micro-organisms) ☐YES ☐NO

B. Nutritional deficiencies? (e.g., malnutrition, or any kind of vitamin deficiency) ☐YES ☐NO

C. Metabolic or immunity disorders? (e.g., metabolism of proteins, minerals, lipids, enzymes or disorders of fluids, electrolytes, acid-base balance or obesity) ☐YES ☐NO

D. Diseases, conditions or parts of the blood or blood forming organs? (inflammation, anemia, coagulation defects, bleeding conditions, hyperspleenism or large spleen, or any blood defects) ☐YES ☐NO

E. Psychological conditions? (e.g., anorexia/belemia, alcohol or drug dependence or mental handicap) ☐YES ☐NO

F. Diseases, conditions or parts of the nervous system or sense organs? (e.g., brain, spinal cord, eyes, meningitis, myelitis, Parkinson's disease, multiple sclerosis, palsy, glaucoma, cataract, narcolepsy, dizziness, epilepsy, or convulsions) ☐YES ☐NO

G. Diseases, conditions or parts of the respiratory system? (e.g., lungs, inflammation, edema, emphysema, asthma, asbestosis, pleurisy, pneumonia, pneumothorax, difficulty breathing, or pulmonary fibrosis) ☐YES ☐NO

H. Diseases, conditions or parts of the digestive system? (e.g., mouth, esophagus, stomach, intestinal tract, rectum, anus, pancreas, liver, gall bladder, problems swallowing, dyspepsia, ulcer, diverticula, hernia, appendicitis, colitis, fissures or fistulas, abscesses, polyp, leukoplakia, bleeding or inflammation) ☐YES ☐NO

I. Diseases, conditions or parts of the genital or urinary systems? (e.g., kidney, bladder, genitalia, prostate, stone, cyst, inflammation, infertility or blood or pus in urine) ☐YES ☐NO

J. Diseases, conditions or parts of female organs, or complications of pregnancy, delivery, or post-delivery? (e.g., uterus, tubes, cervix, any pregnancy, delivery or post-delivery complications, abnormal bleeding, inflammation, unusual menstrual cycle, or endometriosis) ☐YES ☐NO

K. Diseases, conditions or parts of the skin—on or beneath the skin? (e.g., any inflammation, itching, abnormal growth, rashes, psoriasis, or ulcers) ☐YES ☐NO

L. Diseases, conditions or parts of the muscle or skeletal system? (e.g., joints, arthritis, sclerosis, sicca syndrome, myopathy atrophy, rheumatism, fibrositis, back pain, bone/marrow infections, osteoporosis, gout, bursitis, inflammation or any other muscular or bone condition) ☐YES ☐NO

M. Adverse prenatal or postnatal conditions pertaining to fetus or infant? (e.g., hemorrhages, spine or nerve injury, asphyxia, massive aspiration syndrome, hypoxia, rubella, cytomegalovirus, hematological disorders, neonatal diabetes, HIV positive or drug dependency) ☐YES ☐NO

N. Other ill-defined conditions abnormalities or other unusual signs, symptoms or conditions not addressed elsewhere? (e.g., pain or inflammation, allergies, abnormal weight loss/gain, headaches, coma, clubbing of fingers, eating disorder, abnormal bleeding, gangrene, unusual enlargement, inflammation or hardening of any body part or tissues, chronic fatigue, intestinal bypass, loss of limb, or immune deficiency) ☐YES ☐NO

O. Injury or poisoning? (e.g., fractures, dislocations, sprains, internal injuries, amputations, deep contusions, third-degree burns or burns with complications, lead poisoning, frostbite, asbestos or radiation exposure) ☐YES ☐NO

P. Has anyone applying used alcohol, tobacco, or harmful or illegal drugs in the last 10 years? ☐YES ☐NO

IV. LIFETIME MEDICAL HISTORY - Has anyone applying EVER been treated for or had tests, diagnosis, or symptoms for or pertaining to any of the following:

A. Cancer, tumor or abnormal benign growth? (e.g., leukemia, breast or other lump, Hodgkin's disease, or lipoma or lymphoma) ☐YES ☐NO

B. Diseases, conditions or parts of the endocrine system? (e.g., thyroid, parathyroid, pituitary, thymus, adrenal glands, ovaries, testes, pancreatitis, diabetes or swelling or inflammation) ☐YES ☐NO

C. Schizophrenia, paranoia or psychosis? ☐YES ☐NO

D. Diseases, conditions or parts of the circulatory system? (e.g., heart, arteries, veins, capillaries, lymphatic system, swollen lymph nodes, chest pains, heart murmur/disease/attack, rheumatic fever, hypertension/elevated blood pressure, stroke, or varicose veins) ☐YES ☐NO

E. Congenital birth defects? (e.g., spina bifida, hydrocephalus, cleft palate, Hirschsprung's disease, Down's syndrome, deformed or missing limb or body part, genetic defects of blood cells or muscular dystrophy or any other form of dystrophy) ☐YES ☐NO

F. Chronic or incurable diseases or conditions; diseases, conditions or parts of the immune system? (e.g., malaria, hepatitis, shingles, diabetes, hypoglycemia, lupus, tuberculosis, Crohn's disease, rheumatoid arthritis, AIDS/HIV or other chronic sexually transmitted disease) ☐YES ☐NO

G. Has anyone applying ever had a surgical operation or hospitalization? (e.g., cesarean section, tonselectomy or appendectomy) ☐YES ☐NO

H. Has anyone applying ever been advised to have a surgical operation or be hospitalized and not done so? ☐YES ☐NO

I. Has anyone applying ever had an implant, prosthesis or monitoring device? (e.g., breast, chin, pins or plates) ☐YES ☐NO

J. Does anyone applying have a family medical history of diabetes, cancer, or heart problems? (e.g., grandparents, parents, siblings) ☐YES ☐NO

MEDICAL HISTORY EXPLAINATION

If you answered "YES" to any question in the Medical History Questionnaire (page 2), explain further using the chart below. Be sure to use the "correct' example as your guide. You may include explanations for all family members on this page, or make copies and use separate pages for each family member. Additional space is provided on the back side of this page.

Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment Given, and Medications Prescribed
		What is it?	Date that it Started	Date of Recovery (if applicable)		
B	Mr. Doe	blood pressure	1993	N/A	N/A	prescription
		INCORRECT EXAMPLE				
I. B.	John Doe	high blood pressure	4/93	none	no, ongoing	40 mg Atenol once a day
		CORRECT EXAMPLE				

MEDICAL REVIEW QUESTIONNAIRE

1. **For each applicant, for what conditions have you seen a doctor in the last 3 yrs.?** (Please list all doctor visits including wellness checkups)

2. **Has any applicant been hospitalized or had any outpatient surgery within the last 3 yrs.?** (If yes, please explain) ☐ YES ☐ NO

3. **Does any applicant treat with a chiropractor, acupuncturist, or any kind of a homeopathic provider?** (If yes, please explain) ☐ YES ☐ NO

4. **Has any applicant ever smoked or used chewing tobacco?** ☐ YES ☐ NO
   What type?
   How much per day?
   Last used?

5. **Has any applicant ever used alcohol?** ☐ YES ☐ NO
   What type?
   How much per day?
   Last used?

6. **Has any applicant ever had any chronic and/or permanent conditions/illnesses** (e.g. congenital birth defects, STD's, tuberculosis, etc.); anything of that nature? (If yes, please explain) ☐ YES ☐ NO

7. **Has any applicant ever had any kind of cancer or abnormal growths/tumors?** (If yes, please explain) ☐ YES ☐ NO

8. **Have you had any health insurance in the last 6 months?** (If yes, will you be maintaining other health insurance? Explain) ☐ YES ☐ NO

9. **Has any applicant ever been denied health insurance?** (If yes, list the reason) ☐ YES ☐ NO

10. **Does any applicant exercise on a regular basis?** ☐ YES ☐ NO
    What type of exercise?
    How often per week?

11. **What was your weight one year ago?**
    Head of Household:
    Spouse:

12. For adult females: **Are you or could you be pregnant?** ☐ YES ☐ NO

13. For adult females: **When was your last gynecological exam, including pap smear?**
    Date:
    What were the results?

    (If you are over 40 please have the test results sent to us. If you have not had one in the last 12 months this must be done before we can approve your application.)

14. For adult females over 40: **When was your last breast exam mammogram?**
    Date:
    (If you are over 40 please have the test results sent to us. If you have not had one in the last 12 months this must be done before we can approve your application.)

15. For adult males: **When was your last prostate exam?**
    Date:
    (If you are over 40 please have the test results sent to us. If you have not had one in the last 12 months this must be done before we can approve your application.)

16. **Has any applicant had any UNTREATED symptoms such as: neck pain, back pain, headaches, fatigue, heavy menstrual cycles, etc.?** (If yes, please explain) ☐ YES ☐ NO

17. **Has any applicant had any changes in bodily functions such as urination or menstrual cycle?** (If yes, please explain) ☐ YES ☐ NO

18. **Do you have a family history** (parents, grandparents, aunts, uncles, brothers, sisters) **of any of the following?** (If yes, please explain)
    Cancer: ☐ YES ☐ NO

    Heart Disease or high blood pressure: ☐ YES ☐ NO

    Diabetes: ☐ YES ☐ NO

    Any other heredity disease: ☐ YES ☐ NO

19. **Does any applicant take any medications on a regular basis?** (If yes, list the reason) ☐ YES ☐ NO

20. **Is there any other medical treatment, condition, or symptom that you might have forgotten to put on your application?** (Examples: Allergies, Sinuses, Shoulder, Knee Surgeries, Heavy Menstral Cycles, etc.) (If yes, please explain) ☐ YES ☐ NO

ACKNOWLEDGMENTS

I understand that the membership is not insurance but is a voluntary medical needs sharing program, and that there are no representations, promises, or guarantees that my medical expenses will be paid. 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 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 share, 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 the $100 annual membership fee will be refunded automatically if all individuals on my application are declined for membership in the membership or if I withdraw my application prior to my membership effective date. I also understand that the annual membership fee will not be refunded if, in the course of applying for membership, I fail to respond to written or verbal inquiries from Altrua HealthShare for more than sixty days. I also understand that the $25 donation to Altrua 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 payment of my monthly contributions is voluntary and that I am not obligated in any way to send any money.

STATEMENT OF STANDARDS

Because of my biblical convictions, I choose to live a clean and wholesome life, and share the following standards and convictions with members of Altrua HealthShare:

I believe in keeping my body clean with proper nutrition and consuming foods in moderation. I believe that the use of tobacco, illicit drugs, and excessive alcohol consumption is harmful to body and soul. I do not currently use and have not used tobacco or illegal drugs in the past 12 months.

According to the word of God sexual relations outside the bond of marriage between a man and a woman are morally wrong.

I believe that abortion is wrong, except in special circumstances such as rape or serious injury to the mother, and then, only after careful consideration by all concerned.

I believe that I am obligated to provide and care for my family and that abuse of any kind of a family member or anyone else is wrong.

I currently meet each of these standards in my daily life and will continue to do so.

COMMITMENTS

I have read and understand the 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 Altrua HealthShare 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 needs, 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 Membership Eligibility Manual 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 th Altrua HealthShare.

ESCROW INSTRUCTIONS, SIGNATURES AND APPLICATION CHECKLIST

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 needs 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 interpretes 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 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.

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

SIGNATURES

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

(1) That I am aware of and understand each item under ACKNOWLEDGMENTS on page 4 of this application.
(2) That I live according to each item under the STATEMENT OF STANDARDS on page 4 of this application.
(3) That I commit to each item under COMMITMENTS on page 4 of this application.
(4) That I issue the ESCROW INSTRUCTIONS on page 5 of this application to Altrua HealthShare.
(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.

Applicant name (print)	
Signature	Date

Spouse name (print)	
Signature	Date

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

Member: _____ Date:_____

Spouse: _____ Date:_____

CONTRIBUTION PAYMENT INFORMATION

ACH Information (Preferred Method)
I (we) hereby authorize Altrua HealthShare to initiate debit entries of my Application fee, Ministry fee, Annual Renewal fee and recurring Monthly Contribution amount from my financial institution:

◯ Checking Account ◯ Savings Account

Owner's Name (first, last)_____

Financial Institution _____

Routing Number _____

Account Number_____

I authorize Altrua HealthShare to make automatic withdrawals from the account for the amount of my recurring monthly contributions.

Signature: _____ Date: _____

Note: If a change to a financial institution is made, a new ACH authorization form will be needed (see forms and resources), (By placing my name on the signature line represents a signature itself)

Credit Card Information (3% fee to member)

◯ VISA ◯ MASTER CARD

Owner's Name (first, last) _____

Card Number_____

Expiration Date: Month_____ Year_____

CVV Code _____

Application Fee $100.00 Ministry Fee $25.00

Signature: _____ Date:_____

I (we) hereby authorize Altrua HealthShare to initiate debit entries of my Application fee, Ministry fee, Annual Renewal fee and recurring Monthly Contribution amount through the credit card information I have provided.

APPLICATION CHECKLIST

- ☐ Complete each page in its entirety
- ☐ Each adult applying must sign the signatures page
- ☐ Submit Altrua HealthShare Application fee of $100
- ☐ Submit Altrua Ministry Donation of $25
  (Non-refundable "tax" deductible donation)

Submit Application by mail:

Oklahoma Healthcare Exchange
P.O. Box 81
Lindsay, OK 73052-9905

Or by scanning and emailing to:
help@okhcex.com

For Questions call: (855) 786-8343

By submitting the Altrua HealthShare membership Application, you agree that all signatures are valid for the purpose of the financial institution for which the debits for Application fees. Ministry Fees, Annual Renewal fees and recurring Monthly Contribution amounts will be drafted.

Signature of Applicant: _____ Date: _____