Member Information

Amish Mennonite Church Aid

❶ Household demographics

PRIMARY HOUSEHOLD MEMBER

____________________________________ ________ ____________________ Male Female
First name *Initial* *Last Name* *DOB* Last 4 digits of Social Security # *Circle one*

Are you social security exempt? Yes No

Marital status:______________________

If you are covered by Medicare, indicate: Part A Part B
Circle one

SPOUSE

____________________________________ ________ ____________________ Male Female
First name *Initial* *Last Name* *DOB* Last 4 digits of Social Security # *Circle one*

Are you social security exempt? Yes No

If you are covered by Medicare, indicate: Part A Part B
Circle one

CHILDREN / DEPENDENTS *List children under age18.Use a separate application for children 18 or older.*

____________________________________ ________ ____________________ Male Female
First name *Initial* *Last Name* *DOB* Last 4 digits of Social Security # *Circle one*

____________________________________ ________ ____________________ Male Female
First name *Initial* *Last Name* *DOB* Last 4 digits of Social Security # *Circle one*

____________________________________ ________ ____________________ Male Female
First name *Initial* *Last Name* *DOB* Last 4 digits of Social Security # *Circle one*

____________________________________ ________ ____________________ Male Female
First name *Initial* *Last Name* *DOB* Last 4 digits of Social Security # *Circle one*

____________________________________ ________ ____________________ Male Female
First name *Initial* *Last Name* *DOB* Last 4 digits of Social Security # *Circle one*

____________________________________ ________ ____________________ Male Female
First name *Initial* *Last Name* *DOB* Last 4 digits of Social Security # *Circle one*

Starting month of Membership (effective first of the month): ______________________

Household Address:______________________________ City:____________________

State:__________ Zip:______________

Phone:_____________________________ Email/Fax:_________________________

❷ Health History Questionnaire

Complete this page for each person applying for membership in this application. Make copies as needed.

Name: _____ Height: _____ Weight: _____

PAST MEDICAL HISTORY: ☐ NO PAST MEDICAL HISTORY

1. Place a check mark to indicate all past or current medical history. Write in any other medical conditions not specifically identified. Provide comments as necessary for clarity.
2. Circle all the conditions with a historical or anticipated annual expense of $5,000 or more.

Cardiovascular & Circulation:
- ○ highblood pressure
- ○ heart failure
- ○ heart attack
- ○ atrial fibrillation/flutter
- ○ peripheral vascular disease
- ○ blood clots
- ○ heart valve disease
- ○ high cholesterol
- ○ other: _____

Respiratory:
- ○ asthma
- ○ chronic obstructive pulmonary disease
- ○ sleep apnea
- ○ pulmonaryembolus
- ○ other: _____

Neurological:
- ○ dementia
- ○ Parkinson's disease
- ○ seizure disorder
- ○ stroke/mini stroke
- ○ other: _____

Musculoskeletal:
- ○ arthritis
- ○ osteoporosis
- ○ other: _____

Endocrine/Metabolic:
- ○ diabetes type1
- ○ diabetes type 2
- ○ hypothyroid
- ○ hyperthyroid
- ○ other: _____

Gastrointestinal:
- ○ Crohn'sdisease
- ○ acid reflux
- ○ ulcerative colitis
- ○ liver disease
- ○ other: _____

Eye/Ear:
- ○ cataracts
- ○ glaucoma
- ○ macular degeneration
- ○ other:_____

Urinary/Kidney:
- ○ kidneyfailure
- ○ dialysis
- ○ kidney stones
- ○ other:_____

Cancers:
- ○ leukemia
- ○ melanoma
- ○ lymphoma
- ○ other:_____

Blood:
- ○ anemia
- ○ hemophilia
- ○ sickle cell
- ○ other:_____

Mental Health:
- ○ bipolar
- ○ depression
- ○ anxiety
- ○ other:_____

Autoimmune:
- ○ lupus
- ○ other: _____

PAST SURGICAL HISTORY: ☐ NO PAST SURGICAL HISTORY

List any previous surgeries.

_____

_____

CURRENT MEDICATIONS: ☐ NO MEDICATIONS

List all current prescription and over-the-counter medications and supplements including dose and frequency.

_____

_____

_____

_____

❸ Acknowledgements and Authorization

Sign and complete this form for each adult (18 years and older) applying for membership. Make copies as needed.

- I agree to comply with the Amish Mennonite Church Aid (AMCA) Guidelines. I acknowledge that I have an adequate understanding of the Plan and its limitations, and that my participation is strictly voluntary. I understand that the plan will be active on the effective date listed in my application confirmation letter.

- I certify that the information provided in this application is true, accurate, and complete to the best of my knowledge.
- I understand that AMCA is not insurance and should never be construed as a contract for health insurance. I hold ultimate responsibility and am legally liable for the payment of my own medical bills. AMCA offers no legal guarantee and shall not be legally liable for the payment of my medical bills. Further, I understand that no member shall be forced or compelled to make sharing contributions. Contributions from members are voluntary gifts and are non- refundable. If sharing occurs, the shared medical expenses are paid solely from voluntary contributions of members. AMCA serves to facilitate this mutual sharing by managing the members' pooled funds for those who have eligible expenses.

- I authorize AMCA to use and disclose my medical information for purposes of cost sharing, case management, and general organizational use. I grant permission to negotiate and pay bills on my behalf. (I authorize AMCA to discuss and medical bills with my church's contact person.) Any information shared will be limited to what's necessary to support the coordination of my medical care and the sharing of eligible expenses within the ministry.

Signature of applicant

Printed Name

Signature of Church Representative

Application Completion Date

Church Name

Send Completed applications to:
Anabaptist Brotherhood
P.O. Box 144 Guys Mills, PA 16327
Info@AnabaptistBrotherhood.org
Fax: 814-529-0068
Phone: 574-354-4449