



# APPLICATION TO ADD-ON FAMILY MEMBERS

### Before You Begin

- Please review the Impact Guidelines for information on adding on family members and newborns.
- Membership starts on the first of the month following approval. A newborn can be a member from date of birth, provided the application is submitted within 30 days of birth date.
- Please note that adding a family member may affect your share amount. Visit the Share Calculator at [ImpactHealthSharing.com/pricing](http://ImpactHealthSharing.com/pricing)

### Current Member Information

First Name	Last Name	Membership ID
Phone Number	Email	
Address		
City	State	Zip + 4

### New Member Information *Please complete the following information for each family member being added to membership.*

First Name	Last Name
Requested Start Date	Date of Birth (MM/DD/YY)
Relationship to Member <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Height	Weight
What is your occupation?	What is your highest level of education?
Phone Number	Email
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past 12 months, have you used tobacco or vaping products of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently taking any prescriptions or over-the-counter non-vitamin medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the next 12 months, do you expect to have surgery, treatments, or be hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past 12 months, how many times have you been seen by a health care provider? <input type="checkbox"/> Never <input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more times	
In the past 12 months, how many times have you been to the emergency room? <input type="checkbox"/> Never <input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more times	
In the past 12 months, how many times have you been hospitalized? <input type="checkbox"/> Never <input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more times	
Have you experienced unexpected weight changes (weight gain or loss) in the past 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you noted bright red blood in your stool or urine in the past 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you noted black tarry stools in the past 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past 3 years, have you seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following? (Check all that apply)	
<input type="checkbox"/> Cancer <input type="checkbox"/> Cardiac or heart disease/ disorder (e.g. congestive heart failure, bypass, etc.) <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure (hypertension) <input type="checkbox"/> Arthritis (e.g. rheumatoid, osteoporosis, psoriatic, gout) <input type="checkbox"/> Autoimmune Disease (Lupus, "Graves" disease, anemia)	<input type="checkbox"/> Back Disorder (degenerative disc disease, herniated disc, spinal fusion, spondylitis, strain) <input type="checkbox"/> Benign growth (tumor or cyst) <input type="checkbox"/> Bowel (irritable bowel syndrom, Crohn's disease) <input type="checkbox"/> Circulatory system disease (stroke, arterial/vascular disease) <input type="checkbox"/> Immunodeficiency (AIDS, HIV+, hemophilia) <input type="checkbox"/> Kidney Disorder (nephritis, renal failure, kidney disease)
<input type="checkbox"/> Liver Disease (cirrhosis, hepatitis A, B, C, E) <input type="checkbox"/> Mental Illness (depression, anxiety, bipolar disorder, schizophrenia) <input type="checkbox"/> Muscular Disorder (fibromyalgia) <input type="checkbox"/> Respiratory (asthma, allergies, pneumonia, COPD, emphysema, bronchitis) <input type="checkbox"/> Stomach (ulcer, acid reflux, GERD) <input type="checkbox"/> Organ Transplant	<input type="checkbox"/> Endocrine <input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> Nervous System (sleep apnea, epilepsy, MS, muscular dystrophy, Parkinson's, seizures, paralysis, cerebral palsy) <input type="checkbox"/> Skin Disorders (psoriasis, eczema, pre-cancerous lesions) <input type="checkbox"/> Substance Dependency (alcohol, drug) <input type="checkbox"/> None of the above

**ATTENTION:** Impact Health Sharing is not insurance. Impact Health Sharing is a Healthcare Sharing Organization as [outlined in the Patient Protection Affordable Care Act.] Impact Health Sharing is not liable for the payment of a member's medical bill. If sharing occurs, the shared medical bills are paid by the member that incurred the bill from members' share contributions only, not from funds of Impact Health Sharing itself.

Impact Health Sharing is not an insurance product and is not an insurance company. The payment of medical bills through Impact Health Sharing or otherwise is not guaranteed in any way. Impact Health Sharing is not, and should never be construed as, a contract for insurance or a substitute for insurance.

There is no transfer of risk from a member to Impact Health Sharing or from a member to other members; and there is not a contract of indemnity between Impact Health Sharing and any member or between the members themselves.