Impact Health Sharing

# 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

### 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 ☐ Spouse ☐ Dependent | Gender ☐ Male ☐ Female | Height | Weight

What is your occupation? | What is your highest level of education?

Phone Number | Email

Will you have another Health Plan or Insurance after your chosen start date? ☐ Yes ☐ No

If yes, Name of Insurance Co. | Group/Plan ID | Effective Date

Are you pregnant? ☐ Yes ☐ No

In the past 12 months, have you used tobacco or vaping products of any kind? ☐ Yes ☐ No

Are you currently taking any prescriptions or over-the-counter non-vitamin medications? ☐ Yes ☐ No

In the next 12 months, do you expect to have surgery, treatments, or be hospitalized? ☐ Yes ☐ No

In the past 12 months, how many times have you been seen by a health care provider? ☐ Never ☐ 1-2 times ☐ 3 or more times

In the past 12 months, how many times have you been to the emergency room? ☐ Never ☐ 1-2 times ☐ 3 or more times

In the past 12 months, how many times have you been hospitalized? ☐ Never ☐ 1-2 times ☐ 3 or more times

Have you experienced unexpected weight changes (weight gain or loss) in the past 36 months? ☐ Yes ☐ No

Have you noted bright red blood in your stool or urine in the past 36 months? ☐ Yes ☐ No

Have you noted black tarry stools in the past 36 months? ☐ Yes ☐ 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)

- ☐ Cancer
- ☐ Cardiac or heart disease/ disorder (e.g. congestive heart failure, bypass, etc.)
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure (hypertension)
- ☐ Arthritis (e.g. rheumatoid, osteoporosis, psoriatic, gout)
- ☐ Autoimmune Disease (Lupus, "Graves" disease, anemia)
- ☐ Back Disorder (degenerative disc disease, herniated disc, spinal fusion, spondylitis, strain)
- ☐ Benign growth (tumor or cyst)
- ☐ Bowel (irritable bowel syndrome, Crohn's disease)
- ☐ Circulatory system disease (stroke, arterial/vascular disease)
- ☐ Immunodeficiency (AIDS, HIV+, hemophilia)
- ☐ Kidney Disorder (nephritis, renal failure, kidney disease)
- ☐ Liver Disease (cirrhosis, hepatitis A, B, C, E)
- ☐ Mental Illness (depression, anxiety, bipolar disorder, schizophrenia)
- ☐ Muscular Disorder (fibromyalgia)
- ☐ Respiratory (asthma, allergies, pneumonia, COPD, emphysema, bronchitis)
- ☐ Stomach (ulcer, acid reflux, GERD)
- ☐ Organ Transplant
- ☐ Endocrine
- ☐ Alzheimer's/Dementia
- ☐ Nervous System (sleep apnea, epilepsy, MS, muscular dystrophy, Parkinson's, seizures, paralysis, cerebral palsy)
- ☐ Skin Disorders (psoriasis, eczema, pre-cancerous lesions)
- ☐ Substance Dependency (alcohol, drug)
- ☐ None of the above



**To Submit:** **Email** Members@ImpactHealthSharing.com | **Mail** 8210 West State Rd 84, Davie, FL 33324 | **Fax** (954) 678-6970