ALIERA Healthcare

Individual Member Enrollment Form

Member Application

Member Information

Last Name:	First Name:	MI:	Date of Birth:
Sex: ☐ Female ☐ Male	Language:	Social Security Number:	
Street Address:			
City:	State:	Zip Code:	
Email Address:	Authorized to email? ☐ Yes ☐ No		
Phone: ☐ Cell ☐ Home ☐ Work	Phone: ☐ Cell ☐ Home ☐ Work		

Dependent Information

If dependent has a different mailing address, please provide name and address on a separate piece of paper and attach here.*

1. Relationship to Member:				
Last Name:	First Name:	MI:		
DOB:	SSN:	☐ Male	☐ Female	
2. Relationship to Member:				
Last Name:	First Name:	MI:		
DOB:	SSN:	☐ Male	☐ Female	
3. Relationship to Member:				
Last Name:	First Name:	MI:		
DOB:	SSN:	☐ Male	☐ Female	
4. Relationship to Member:				
Last Name:	First Name:	MI:		
DOB:	SSN:	☐ Male	☐ Female	

Membership Plans

Please select your plan* (For plan choices and complete plan descriptions, please visit www.alierahealthcare.com)

**Note: Enrollment must be completed before the 15th of the month before desired effective date AND the first month's payment received. Effective date cannot be back-dated.*

Type of plan: ☐ New ☐ Modified | Reinstatement ID # | Desired Effective Date:

☐ **AlieraCare Value | Plus | Premium**	☐ Value ☐ Plus ☐ Premium			☐ 5,000 MSRA ☐ 7,500 MSRA ☐ 10,000 MSRA		
☐ **CarePlus**	☐ 150,000 Catastrophic Sharing Limit ☐ 250,000 Catastrophic Sharing Limit ☐ 500,000 Catastrophic Sharing Limit			☐ 5,000 MSRA ☐ 10,000 MSRA		
☐ **InterimCare**	Per Term	☐ 0-30 Days ☐ 31-180 Days ☐ 181-364 Days		☐ Value ☐ Plus ☐ Premium	☐ 1,500 MSRA ☐ 2,500 MSRA ☐ 5,000 MSRA ☐ 10,000 MSRA	
☐ **AlieraCare Bronze | Silver | Gold**	☐ Bronze ☐ Silver ☐ Gold			☐ 1,500 MSRA ☐ 2,500 MSRA ☐ 5,000 MSRA ☐ 10,000 MSRA		
☐ **PrimaCare & PrimaCare Senior**	☐ PrimaCare ☐ PrimaCare Senior			☐ Standard ☐ Premium		
☐ Trinity Dental & Vision Care	☐ Trinity Dental Care			☐ Trinity Vision Care		

Trinity HealthShare, Inc. Product Disclosures & Sharing Eligibility

TRINITY HEALTHSHARE, INC ("Trinity") IS A CERTIFIED HEALTH CARE SHARING MINISTRY ("HCSM"). TRINITY IS NOT AN INSURANCE COMPANY AND TRINITY DOES NOT OFFER ANY INSURANCE PRODUCTS OR POLICIES. TRINITY DOES NOT ASSUME ANY RISK FOR YOUR MEDICAL EXPENSES, AND TRINITY MAKES NO PROMISE TO PAY. HEALTH CARE SHARING MINISTRIES ARE NOT GOVERNED BY INSURANCE LAWS.

TRINITY HEALTHSHARE, INC OFFERS PARTICIPATION IN ITS HEALTH CARE SHARING MINISTRY. TRINITY MEMBERSHIPS ARE ADMINISTERED BY ALIERA HEALTHCARE, INC.

1. Health Care Sharing Ministry

HCSM IS NOT INSURANCE

A Health Care Sharing Ministry ("HCSM") is a group of individuals that share a common set of ethical or religious beliefs and share their medical expenses in accordance with those beliefs without regard to the state in which a member resides or is employed.

The membership is based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices regarding health and care, and believe in helping others. The HCSM HealthShare membership is NOT health insurance.

2. Tax Exemption

Members of Trinity sharing plans are exempt from the Individual Shared Responsibility Payment (Tax Penalty) under the rules of the Patient Protection and Affordable Care Act ("ACA"). This exemption is available because the Center for Consumer Information & Insurance Oversight certified Trinity as a health care sharing ministry.

Under the ACA, health care sharing ministries can be certified by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight. The test for such certification can be found in Section 5000A of the Internal Revenue Code (26 U.S.C. § 5000A).

If you choose to participate in the Trinity health care sharing ministry, and you have not had a break in your health care benefits of more than 90 days, you are exempt from the individual tax penalty, assuming you meet all other requirements for the tax year.

YOU SHOULD CONSULT WITH A TAX PROFESSIONAL FOR DETAILS REGARDING YOUR EXEMPTION.

3. HCSM Disclosures

1. No Promise to Pay

   Trinity does not make a promise to pay or any guarantee of payment of your medical expenses. You will be responsible for the payment of your medical bills. Trinity does not assume your risk. Trinity does not guarantee that your medical expenses will be shared by other members of Trinity HCSM.

2. Voluntary

   Participation in the Trinity HCSM is voluntary. Enrollment as a member of Trinity HCSM is voluntary and the sharing of monetary contributions are also voluntary. Enrollment in a Trinity sharing plan is not a contract. You are free to cancel your participation at any time. Trinity requests a Monthly Share Amount, to be collected each month you are enrolled, to facilitate the payment of sharing requests published on behalf of other members.

3. Guidelines

   Trinity manages its member sharing contributions by establishing guidelines that define eligible sharing ("Guidelines"). The Guidelines are not a contract of insurance. They do not constitute an agreement, a promise to pay, or an obligation to share. The Guidelines are intended to ensure that every member has paid their own medical expenses, as they are financially able, before requesting other members to share with you to assist in paying remaining medical expenses. The Guidelines specify what type of expenses are eligible for sharing requests, so all members of Trinity HCSM can expect a reasonable and equitable level of sharing requests to be published monthly.

4. Pre-Existing Conditions

   Trinity is authorized to exclude sharing for pre-existing conditions. You are required to fully disclose pre-existing conditions as part of your enrollment in the HCSM. Trinity reserves the right to exclude sharing eligibility for any pre-existing conditions, whether disclosed at the time of your enrollment or discovered after the effective date of the membership.

AlieraCare - Value, Plus, and Premium Plans

- Pre-existing conditions have a 24-month waiting period.
- Cancer diagnoses after enrollment have a 12-month continuous membership requirement before sharing is eligible. This means that if you are diagnosed with cancer after you become a member, you are not eligible to request costs sharing of your expenses until you have been a member for 12 consecutive months.

AlieraCare - Bronze Plan

- Chronic or recurrent conditions that have evidenced signs/symptoms and/or received treatment and/or medication within the past 24 months are not eligible for cost sharing during the first 24 months of membership.
- Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition cost sharing limitations.

Appeals may be considered for earlier cost sharing in surgical interventions when it is in the mutual best interest of the individual members and the membership as a whole to do so.

Trinity HealthShare, Inc. Product Disclosures & Sharing Eligibility cont.

AlieraCare - Silver Plan

- During the first two years of continuous membership, cost sharing is available up to $10,000 of your total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.
- Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition cost sharing limitations.

Appeals may be considered for earlier cost sharing in surgical interventions when it is in the mutual best interest of the individual members and the membership as a whole to do so.

AlieraCare - Gold Plan

- During the first two years of continuous membership, cost sharing is available up to $20,000 of your total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.
- Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition cost sharing limitations.

Appeals may be considered for earlier cost sharing in surgical interventions when it is in the mutual best interest of the individual members and the membership as a whole to do so.

CarePlus

- Cost sharing does not apply (not eligible) to any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within the 24-month period prior to the application date.
- Events covered during the first year of membership become pre-existing condition for the second year, resetting after 24 months.

InterimCare

- Pre-existing conditions have a 24-month waiting period.
- Cancer coverage is provided immediately if a pre-existing cancer condition did not exist within 5 years prior to or at the time of application.
- Charges resulting directly from a pre-existing condition are excluded from cost sharing.

The pre-existing condition exclusions for Interim Care plans will apply for all members, including those under the age of 19.

5. Dates of Service

Trinity reserves the right to make updates to the Guidelines at any time. The Guidelines in effect at the time of service will supersede all previous versions of the Guidelines. Members will be notified in advance of updates to the Guidelines.

6. Membership Dues and Fees
   - Membership dues of $125.00 are requested at the time of initial enrollment, and $75.00 annually upon renewal, by the 5th day of the member's annual renewal month, as provided in the Guidelines.
   - An administrative fee of $25.00 is assigned to administrative costs from each Monthly Share Amount regardless of family size, as provided in the Guidelines. Collection of this fee will begin in the third membership month, and will be collected monthly for each following month.
7. Assigned Need

Trinity will assign a recommended cost sharing amount to the membership each month ("Monthly Share Amount"). By submitting the Monthly Share Amount, you instruct Trinity to assign your contribution as prescribed by the Guidelines.

During the first two months of membership, the Monthly Share Amount will be sent to Trinity to be used at the discretion of the HCSM. On the third month of membership, each member is assigned a "Share Box" (a secure, online contribution sharing program) which facilitates the cost sharing of contributions among the members of Trinity HCSM.

8. Guidelines Details

Each member is responsible for reviewing the Guidelines provided at the time of enrollment, and to abide by the terms of the Guidelines. It is your responsibility to understand which of your medical expenses are eligible for cost sharing, and which medical expenses are NOT eligible for cost sharing. Members are also provided with a toll-free number to contact Member Services with any questions they have. It is recommended that members call Member Services with any questions regarding eligibility prior to seeking medical services.

9. Authorizations

I understand that Trinity offers participation in the health care sharing ministry, and I understand that Aliera administers memberships on behalf of Trinity.
   - I authorize Aliera Healthcare, Inc. ("Aliera"), on behalf of Trinity, to collect the Monthly Share Amount.
   - I authorize my first Monthly Share Amount to be processed immediately upon completion of my enrollment.
10. Acknowledgment
   - I affirm that the name and personal information provided on this form are true and correct.
   - I affirm that I understand and accept the disclosures presented above.

Aliera Healthcare, Inc. Product Disclosures

Disclaimer

ALIERA IS NOT AN INSURANCE COMPANY AND ALIERA DOES NOT OFFER ANY INSURANCE PRODUCTS OR POLICIES. YOU DO NOT HAVE ANY RIGHTS OR PROTECTIONS UNDER ANY INSURANCE LAWS.

1. Direct Primary Care Disclosures

Direct Primary Care Medical Home ("DPC") is an innovative alternative payment model designed to provide greater access to primary care with a simple, flat, affordable membership fee. There is no balance billing from your medical providers because your monthly membership fee pays for your primary care. You pay a flat monthly membership fee, and in return, you can visit your primary care provider, who has agreed to provide medical services in exchange for that monthly membership fee. No insurance is involved. You pay your monthly membership fee, follow the program utilization procedures, and receive preventive and wellness care offered by your primary care provider. Because this is not insurance, there are no out of network benefits. You will be contracted with a specific provider in your local community who has agreed with Aliera Healthcare, Inc. ("Aliera") to provide you primary care services.

2. How It Works

Aliera has contracted with thousands of primary care providers around the United States. When you enroll in one of Aliera's DPC medical service plans, Aliera will match you to a primary care provider in your area. Each month, Aliera will collect your membership fee and direct payment to your matched primary care provider. You will receive all your primary care (including preventive and wellness) from your primary care provider. DPC does not include medical services other than primary care.

3. What Do I Need to Know?

1. You need to know that this is not insurance. This DPC medical services plan will create a direct relationship between you and your primary care provider. There is no insurance company involved in this membership. Your monthly membership fees will be used to pay your primary care provider monthly, and in return you will be authorized to seek medical services from that provider.
2. This is a voluntary program offered by Aliera. Your membership cannot be transferred to anyone else. Only you and your enrolled dependents can receive primary care services using your membership.
3. You will pay for your DPC services on a month by month basis, and you may cancel your membership at any time by providing Aliera written notice. If your monthly fee has already been processed when Aliera receives your written cancellation notice, we will pro-rate the monthly membership fee based on the number of days remaining in that service month and refund you for the days that remain in that period. We agree to process any refund you may be due within 10 business days of receiving your written cancellation notice.
4. You are free to change your primary care provider by contacting Aliera, but you must select a provider who has contracted with Aliera to provide DPC medical services. If you receive primary care services from a provider other than your matched primary care provider, you will be responsible for payment of those services.
5. Aliera may change the monthly fee for your DPC membership only once per calendar year. Aliera may also add or discontinue services. You will receive 30 days' notice if there is a change in the monthly fee for your DPC membership or any change in services available.
6. Aliera reserves the right to terminate your membership but will provide you 30 days' notice of such termination. Aliera will not terminate any membership based solely on your health status, or the health status of your enrolled dependents. If Aliera terminates your membership during a service month, your fee will be pro-rated based on the number of days remaining in that service month and will issue a refund within 10 days of the termination date.
7. Aliera is the program manager of your DPC medical services plan. As the program manager, Aliera may maintain a record of your health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. Aliera is required by law to protect the privacy of your health information. Aliera will provide you with the Notice of Privacy Practices.
8. If you are enrolled in Medicare, Aliera will provide you with a "Medicare Opt-Out Agreement" to review and sign before your first appointment with your primary care provider. This is necessary to ensure you understand that your Aliera primary care provider is not allowed to submit claims to Medicare for medical services provided under the DPC medical services plan. You are free to continue receiving medical services from your Medicaid providers while you are a member receiving primary care services under the DPC plan.

4. Direct Primary Care Member Responsibilities

1. It is your responsibility to carefully read all information provided to you about the benefits of the DPC medical services plan, and to abide by the member guide that includes Detailed Terms of Service provided to you. Aliera representatives are available to answer any questions you may have about your membership.
2. It is your responsibility to be fully informed and understand what medical services the DPC medical services plan provides, and how to access them before you seek the services of a provider. If you do not follow Detailed Terms of Service, you will be responsible for paying for your medical expenses.
3. You must set up a Telemedicine account. The DPC medical service plan requires members to seek assistance from Telemedicine providers before making appointments with primary care providers. This helps to keep the cost of the DPC plan affordable, and often results in much faster access to a medical professional.

Aliera Healthcare, Inc. Product Disclosures cont.

4. You should always use the Aliera Concierge Service and Care Coordination to schedule appointments with primary care providers or urgent care facilities. This service will help you to receive medical services included in your DPC membership.
5. You are responsible for providing accurate membership information about yourself and your dependents enrolled in your membership. Inaccurate, missing, or false information can lead to delays or denial in receiving medical services.

By my signature below, I agree to become a voluntary subscriber to Trinity HealthShare, Inc., and a member of Aliera Healthcare, Inc. I certify that I have read and understand the disclosures listed above.

Signature: _____ Printed Name: _____

Date: _____ Signature By: ☐ Member ☐ Parent ☐ Legal Guardian

Payment Options

Payment:	☐	Credit Card	☐	ACH	Total Member Fee $ (Drafted on a recurring basis)	Total Enrollment Fee $ (One-time fee)

Credit Card

Name on Card:	Card Type:	☐	Visa	☐	MasterCard	☐	Discover
Card Number:			Exp:		CVC:		
Card Billing Address:							

ACH (Please attach a voided company check to this form)

Bank Name:	Account Type:	☐	Checking	☐	Savings
Name on Account:	Account Number:		Routing Number:		

The following authorization applies only to Individual Member plans. Individuals enrolled through an Employer should contact their employer for details about their plan.

By signing below, I hereby authorize Aliera and Trinity to contact me using the information I have provided via on-line enrollment. Further, I hereby authorize Aliera and Trinity, in accordance with each program's corresponding charge requirements, to initiate charges to my credit card, debit card or bank account for my initial and recurring fees and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the separate transaction amounts for each plan represent the total of my plan fee plus the separate plan fees of any dependents on my account. This approval is given regardless if the agreement submitted is in my name, the name of the Primary Member listed herein, or the name of one of the dependents listed under the Primary Member. I understand that the plan fees charged to my credit card will be accurately reflected as those shown on the plans or the most recent fees change via notifications issued to the Primary Member (the subscriber) by Aliera or Trinity. This authorization is I provide Aliera or Trinity a 30-day written notification of cancellation of these plans.

- *This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until Aliera or Trinity has received written notification of plan termination as outlined above.*
- *I understand that my participation in Aliera and Trinity is continuous and that, by signing below, I authorize recurring credit/debit card charges for the individual listed.*
- *I understand that a $25 fee will be charged to me for declined credit or debit card transactions, including recurring transactions, that are not honored.*

Signature: _____ Printed Name: _____

Date: _____

Health Assessment and Attestation

Member Information

Please take a few minutes to answer the following questions. The information will be reviewed by Trinity when necessary to determine sharing eligibility. Please fill out one form per member, including dependents.

Last Name:	First Name:	MI:	Date of Birth:
Sex: ☐ Female ☐ Male	Member ID:	Today's Date:	
Street Address:			
City:	State:	Zip Code:	

1. Check each item you currently have, or you have had in the past 24 months*

☐	Arthritis	☐	Measles	☐	Weight change
☐	Asthma	☐	Mumps	☐	Thyroid problems
☐	Heart Disease	☐	Tumor/cancer	☐	Eating disorder
☐	Congestive Heart Failure	☐	Eye problems	☐	Liver disease/Hepatitis
☐	Heart Bypass Surgery	☐	Anemia	☐	Broken bones
☐	Depression	☐	Chronic cough	☐	Bone or joint problems
☐	Diabetes Type I	☐	Shortness of breath	☐	Immune suppression
☐	Diabetes Type II	☐	Lung problems	☐	Knee pain/injury
☐	Chronic Heartburn/GERD	☐	Gout	☐	Foot pain/injury
☐	High Cholesterol	☐	Chest pain	☐	Neck pain/injury
☐	High Blood Pressure	☐	Bleeding or blood disorder	☐	Loss of limb
☐	Irritable Bowel Disease	☐	Heart murmur	☐	Severe headaches
☐	Lower Back or Neck Pain	☐	Stroke or paralysis	☐	Dizziness or fainting
☐	Heart Attack	☐	AIDS/HIV	☐	Epilepsy or seizures
☐	Chicken Pox or Shingles	☐	Kidney disease	☐	Anxiety
☐	Stomach or intestinal problem	☐	Chronic or recurrent infection	☐	Severe weakness or tiredness
☐	Emotional or psychiatric problems	☐	Palpitations or irregular heart beat	☐	Tuberculosis or positive TB skin test
☐	Drugs or alcohol dependency	☐	Numbness or tingling of legs or feet	☐	Hearing loss or ear problems
☐	Shoulder/elbow/wrist/hand pain	☐	Numbness or tingling of arms or hands	☐	Skin problems or chronic rash

2. Please list all other health concerns that you have:

3. What is your weight?		What is your height?		
4. Do you smoke?	☐	Yes	☐	No
If yes, how often:				
5. Do you currently have or have had cancer?	☐	Yes	☐	No
If yes, how long ago:				
6. Do you play competitive sports?	☐	Yes	☐	No
If yes, please list all competitive sports in which you participate:				
7. Do you drink?	☐	Yes	☐	No
If yes, how much: ☐ 1-3 weekly	☐	4-7 weekly	☐	8+ weekly
8. Are you pregnant?	☐	Yes	☐	No

* Includes chronic conditions for which you have experienced signs/symptoms, and/or received treatment and/or medication within the past 24 months.

Members must agree to the following Trinity HealthShare **Statement of Beliefs** to be approved for inclusion in an Trinity sharing plan:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need, according to our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors, or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare, in consultation with physicians, family, or other valued advisors.

Do you agree with this Statement of Beliefs? ☐ Yes ☐ No

Signature: Printed Name:

Date:

SUBMIT TO: Your broker at

ColoradoHealth.com via email, or fax at

303-782-0804.

Include any important information in the body of your email

or fax cover sheet.