CHRISTIAN MUTUAL MED-AID

Operated by Logos Missions, Inc.

Application Form

Re-apply (재가입)	
CMM ID #:	

Please print using black ink. (인쇄체로 검은 잉크를 사용하세요)

www.LogosMissions.org

CHECK ONE: (해당란에 ✓표시하십시오.) ☒ **ONE UNIT** (1인) ☐ **TWO UNITS** (2인) ☐ **THREE UNITS** (3인이상)

Referred by (소개자 이름): Member ID:

☐ Friend ☐ Conference ☐ Directory ☒ Internet ☐ Newspaper ☐ Radio/TV

1st (가입자)

SELECT PROGRAM (프로그램을 선택하십시오.): ☐ Gold Plus ☐ Gold Medi-I ☐ Gold ☐ Silver ☒ Bronze

Last Name	First	Middle
Kim	Julie	S

Date of Birth	Social Security #	Gender
10 / 11 / 1991		☐ M ☒ F

Address	Apt. #
22304 68th PL W	

City	State	Zip Code
Mountlake Terrace	WA	98043

Primary ☎:	Secondary ☎:	E-mail Address:
4255020058		julie.suhyoung.kim@gmail.com

* Qualifications for CMM members: Faithful Christians who abstain from ALCOHOL, TOBACCO and ILLEGAL DRUGS. Please mark the item: (회원 자격은 술, 담배, 불법 약물을 사용하지 않는 크리스찬입니다. 아래 항목을 사용하고 있다면 "Y", 아니면 "N"로 표기해 주십시오.)

I CURRENTLY USE, "Y" for YES, "N" for NO:
• Alcohol (N) • Tobacco (N) • Illegal Drugs (N)

I FORMERLY USED, "Y" for YES, "N" for NO:
• Alcohol (N) • Tobacco (N) • Illegal Drugs (N)

2nd (배우자)

SELECT PROGRAM (프로그램을 선택하십시오.): ☐ Gold Plus ☐ Gold Medi-I ☐ Gold ☐ Silver ☐ Bronze

Last Name | First | Middle

Date of Birth / / | Social Security # | Gender ☐ M ☐ F

Primary ☎: | Secondary ☎: | E-mail Address:

IF CURRENTLY BEING USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

IF FORMERLY USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

3rd (자녀)

AN ADULT DEPENDENT MEMBER AGED FROM 18 TO 25 IS REQUIRED TO SUBMIT THE PROOF OF DEPENDENT QUALIFICATION TO CMM EVERY YEAR. (부양 가족으로 등록된 18세에서 25세 사이의 성인 자녀가 있는 경우는 매년 부양 증명 서류를 CMM에 제출해야 합니다.)

SELECT PROGRAM (프로그램을 선택하십시오.): ☐ Gold Plus ☐ Gold ☐ Silver ☐ Bronze

Last Name | First | Middle

Date of Birth / / | Social Security # | Gender ☐ M ☐ F

IF CURRENTLY BEING USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

IF FORMERLY USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

SELECT PROGRAM (프로그램을 선택하십시오.): ☐ Gold Plus ☐ Gold ☐ Silver ☐ Bronze

Last Name | First | Middle

Date of Birth / / | Social Security # | Gender ☐ M ☐ F

IF CURRENTLY BEING USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

IF FORMERLY USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

SELECT PROGRAM (프로그램을 선택하십시오.): ☐ Gold Plus ☐ Gold ☐ Silver ☐ Bronze

Last Name | First | Middle

Date of Birth / / | Social Security # | Gender ☐ M ☐ F

IF CURRENTLY BEING USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

IF FORMERLY USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

SELECT PROGRAM (프로그램을 선택하십시오.): ☐ Gold Plus ☐ Gold ☐ Silver ☐ Bronze

Last Name | First | Middle

Date of Birth / / | Social Security # | Gender ☐ M ☐ F

IF CURRENTLY BEING USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

IF FORMERLY USED, "Y" for YES, "N" for NO:
• Alcohol ( ) • Tobacco ( ) • Illegal Drugs ( )

CHRISTIAN MUTUAL MED-AID (CMM) IS NOT AN INSURANCE PROGRAM. CMM IS A HEALTH CARE SHARING MINISTRY. The first day of month below is your actual membership start date. The start date shall not be effective retroactively or changed under any circumstance after the application is received. If the application is received by CMM before the 25th day of the each month, the membership will be effective from the following month.

(기독의료상조회는 의료보험회사가 아니며, 의료비 나눔 사역 단체입니다. 회원 자격은 신청서에 귀하가 요청한 달의 1일부터 시작됩니다. 신청서는 시작을 원하시는 달의 전월 25일까지 접수 되어야 합니다. 회원 자격시작일은 소급 적용 되지 않으며, 신청서가 사무실에 접수된 이후에는 변경할 수 없습니다.)

☐ **I would like my membership to begin the first day of** ______ / ______ (Month) (Year). **I have enclosed my first gift of $** ______________ (Amount).

All CMM members agree to share qualifying medical bills that exceed the ministry's current $150,000 lifetime limit per (related) illness.

(기독의료상조회 전체 회원은 한 질병당 15만 불 이상의 의료비가 나오는 회원이 있을 경우, 초과된 의료비를 전체 회원이 나누어 분담합니다.)

Please send my Gift Reminder via (Select one or both): ☐ Mail ☒ Email

Please make check payable to: CHRISTIAN MUTUAL MED-AID (개인 수표를 Christian Mutual Med-Aid 앞으로 발행해 주십시오.)
5235 N. Elston Ave. Chicago, IL 60630

I attend Bellevue Pilgrim Presbyterian Church
Church Name (출석교회 이름)

Pastor ☒ 목사 | Elder ☐ 장로 | Deacon ☐ 권사 ☐ 집사 | Member ☐ 성도
Member's Position (회원직분)

Pastor Name (담임목사) Youngsik Kim

☎ Tel

Church Address 6016 120th Ave Se, Bellevue WA 98006

Health History : 건강확인서

Has any person listed on the application form received medical treatments or undergone surgeries for the illnesses below? Please circle Y for yes, N for no in the box of the person. If you answer 'Yes" to the questions, please provide a brief explanation in the comments box below.

신청서에 이름이 있는 사람들 중에 아래의 병으로 치료를 받았거나 수술을 받은 사람이 있습니까?

해당되는 사람의 박스에 받은 적이 있으면 Y, 없으면 N 에 체크해 주세요. "Yes" 라고 대답했다면 아래 참고란에 간단한 설명을 적어 주십시오.

As required by law, our ministry adheres to written policies and procedures to protect the privacy of information about you and your family that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. If an applicant fails to fully disclose the health history, withholds any relevant information, or provides false or wrong information, any submitted bills shall be refused. (기독의료상조회는 본회가 작성, 수령, 관리하는 귀하와 가족들의 개인정보를 보호하기 위해서 법이 요구하는 서면 규정과 절차를 준수합니다. 귀하의 답변은 본회의 기록만을 위한 것이며 해당 법률에 따라 기밀로 처리됩니다. 신청인이 건강 기록을 완전히 공개하지 않고 어떤 정보를 숨기거나, 허위 또는 잘못된 정보를 기재하는 경우, 제출된 신청서는 접수되지 않습니다.)	PRIMARY 본인	SPOUSE 배우자	CHILD 1 자녀 1	CHILD 2 자녀 2	CHILD 3 자녀 3	CHILD 4 자녀 4
Have you or anyone in your household had symptoms, treatments or diagnoses of any doctor during the past 5 years (Including without limitation regular check-ups)? 본인이나 가족 중에 지난 5년간 건강 상태와 관련해 증상이 있거나, 치료 또는 진단받은 적이 있습니까 (정기검진 포함)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you or anyone in your household had symptoms, treatments or diagnoses of high blood pressure, diabetes, heart diseases or vascular diseases? 본인이나 가족 중에 고혈압, 당뇨병, 심장병, 뇌졸중, 및 혈관 질환의 증상이나, 진단 및 치료를 받으신 적이 있으십니까?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you or anyone in your household had symptoms, treatments or diagnoses of allergies, asthma or respiratory problems? 본인이나 가족 중에 알레르기, 천식 및 호흡기 질환의 증상이나, 진단 및 치료를 받으신 적이 있으십니까?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you or anyone in your household had symptoms, treatments or diagnosed of arthritis, rheumatoid, arthritis, chronic back pain, muscular or skeletal or nervous systems? 본인이나 가족 중에 관절염, 류마티스, 척추 및 신경계통, 근/골격계 질환의 증상이나, 진단 및 치료를 받으신적이 있으십니까?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you or anyone in your household had symptoms or medical conditions related to eyes, nose, ears, hands, feet? 본인이나 가족 중에 눈, 코, 귀, 손, 발 관련 질환의 증상이나, 진단 및 치료를 받으신 적이 있으십니까?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you or anyone in your household had symptoms or medical conditions related to stomach, liver, colon, kidney or any internal organs? 본인이나 가족 중에 위, 간, 대장, 신장 및 장기 관련 질환의 증상이나, 진단 및 치료를 받으신 적이 있으십니까?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you or anyone in your household had symptoms or medical conditions related to thyroid, tumor or cancer? 본인이나 가족 중에 갑상선, 각종 종양 및 암 관련 질환의 증상이나, 진단 및 치료를 받으신 적이 있으십니까?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you or anyone in your household had symptoms or medical conditions related to prostate or female reproductive organs? 본인이나 가족 중에 전립선 또는 여성 질환과 관련해 증상이 있거나, 치료 또는 진단 받은 적이 있습니까?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Have you or anyone in your household had congenital diseases or symptoms or other related medical conditions? 본인이나 가족 중에 선천적 질환과 관련해 증상이 있거나, 치료 또는 진단 받은 적이 있습니까?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Name 이름	Treatment Date 치료일자	Diagnosis 병명 | Duration 기간 | Results 결과 | Tests Performed 검사 | Medication 투약 | Outcome 경과	Attending Physician's Name, Address and Phone Number 의사이름, 주소 및 전화번호

The Christian Mutual Med-Aid ("CMM") Guidelines (collectively "Guidelines") that are currently in effect are, in their entirety, incorporated and made part of this application ("Application") by reference. By the execution and submission of the Application, any and all applicants ("Applicants") whose names are included and listed in the Application agree and confirm that they are subject to all the terms and conditions of the Guidelines. (이 신청서의 모든 내용은 현재 시행 중인 기독의료상조회 이하 CMM) 가이드라인을 기반으로 작성되었습니다. 신청서에 이름이 적힌 모든 신청인들은 가이드라인의 약관에 동의하였음을 확인합니다.)

By the submission of the Application, Applicants attest that they are Christians, live by the Biblical principles and attend church regularly. Furthermore, by the submission of the Application, Applicants specifically attest that they abstain from tobacco, the use of Illegal drugs and the unlawful or unauthorized use of the medications, whether prescribed or not, follow the Biblical teachings on the use of alcohol and commit themselves to the commands of Jesus Christ in the Bible. Applicants declare that any and all information provided on the Application is complete, true and correct and accept and agree that the CMM retains the compete and unrestricted right to terminate any membership of any Applicant immediately and retroactively to the date of the Application in the even that any such Applicant provides incomplete, untrue or incorrect information on the Application. (신청서에 따라 신청인은 기독교인이며, 성경적인 원칙에 따라 생활하고, 정기적으로 예배에 참석하고 있음을 증명합니다. 또한 신청서에 따라 신청인은 금연하며, 불법 약물을 사용하지 않고, 처방약 또는 비처방약의 오남용을 하지 않으며, 음주에 관해 성경의 가르침을 따르고, 성경에 있는 예수 그리스도의 명령에 순종하고 있음을 증명합니다. 신청인은 신청서에 모든 내용을 숨김 없이, 진실되고, 정확하게 기입했음을 분명히 밝힙니다. 신청인은 신청서에 기입된 내용이 완전하지 않거나, 거짓이거나, 정확하지 않을 경우 CMM이 즉시 또는 소급해서 회원자격을 취소할 모든 권한이 있다는 것을 인정하고 동의합니다.)

The role of the CMM is solely limited to that of the facilitator that assembles the members with resources and assist them to provide mutual help with medical costs. Applicants accept and agree that any dispute or disagreement of theirs with the CMM shall be resolved through Christian alternate dispute resolution including without limitation Christian mediation and Christian arbitration as provided by the Guidelines and unequivocally waive any rights to file legal or equity actions in the court of law or claim against the CMM or its owners, Logos Missions, Inc., or any of their officers, directors, employees or agents. Applicants accept and agree that they will receive Gift reminders by the 10th of each month. (CMM의 역할은 회원들로부터 기금을 모으고 가이드라인에 따라 의료비 지원을 돕는 것에 국한됩니다. 신청인는 CMM과의 논쟁 또는 의견 충돌이 있을 경우 가이드라인에 명시된 데로 제한없는 크리스천 중재나 크리스천 조정을 포함한 크리스천 대체 분쟁 해결 방법을 통해 해결할 것을 인정하고 동의합니다. 그리고 신청인은 CMM이나 로고스 선교회의 임직원 또는 에이전트들을 상대로 법적 소송을 제기할 권리를 완전히 포기할 것을 인정하고 동의합니다. 회비 안내서는 매달 10일에 발송합니다.)

By signing this application, I certify that I am authorized to and do apply for the CMM memberships on behalf of myself and all of my included family members and accept and agree to all terms and conditions of a membership. (이에 서명함으로써, 본인은 가족을 대표하여 모든 내용에 영문 이니셜을 기입했으며, 위의 내용을 숙지하였으며, 동의했음을 확인합니다.)

Signature of Primary _____ **Date** 3 / 1 / 2018

At the present time your plenty will supply what they need, so that in turn their plenty will supply what you need. Then there will be equality (2 Corinthians 8:14)

CHRISTIAN MUTUAL MED-AID
Operated by Logos Missions, Inc
기독의료상조회
5235 N. Elston Ave. | Chicago, IL 60630 | Phone 773.777.8889 | Fax 773.777.0695 | www.cmmlogos.org

INITIAL		Membership Agreement & Checklist of Understanding
Primary	Spouse	The Primary Member, on behalf of the entire household, must read, initial, and sign the following:
JK		I (We) understand that CMM members share one another's burdens according to the Biblical teachings of Galatians 6:2, 10(b), Acts 4:35(b), and 2 Corinthians 8:14.
JK		I (We) understand that CMM is a health care sharing ministry, not a health insurance company, and, as such, that CMM guarantees nothing to its participating members. I (We) further understand that CMM is not approved nor endorsed by the Department of Insurance in my (our) State of residence, and that my claims or losses are not protected by my (our) State's Guaranty Fund.
JK		I am a (We are) Christian(s) that live(s) according to Biblical principles and attend(s) church regularly.
JK		I (We) abstain from tobacco, illegal drugs, the improper or unauthorized use of prescription medications or over-the-counter medications, and abuse of alcohol. I (We) also do not engage in unbiblical married life.
JK		I (We) understand that my (our) monthly Gift to support other members is due by the 1st of the month.
JK		I (We) understand that qualifying medical bills for the new member will be eligible for sharing after a 90-day waiting period.
JK		I (We) understand that the eligibility of my (our) submitted medical bills is determined in accordance with the CMM Guidelines.
JK		I (We) understand that medical expenses that occurred prior to my (our) membership will not be supported by CMM.
JK		I (We) understand that I am responsible for my (our) medical bills regardless of whether CMM will support my (our) medical bills or whether CMM continues to operate.
JK		I (We) understand that I (we) must notify CMM prior to seeking medical services.
JK		I (We) understand that I (we) must register as a Self-Payer with all medical providers.
JK		I (We) understand that I must request discounts, fee adjustments, or financial assistance, such as Charity Care, from all medical providers.
JK		I (We) understand that I (we) must complete a Needs Processing Packet and submit itemized bills before my medical bills can be processed.
JK		I (We) understand that all members must support and contribute to another member's excess medical bills when the qualifying medical need exceeds $150,000 through Burden-Sharing.
JK		I (We) understand that my (our) monthly Gift will increase by 0.1% per dollar shared if my (our) shared need exceeds $10,000.
JK		I (We) understand that no legal contract or obligation exists between CMM and the individual member regarding indemnification of medical expenses.
JK		I (We) understand that CMM members submit monthly Gifts for the purpose of sharing one another's burdens. As such, I (we) further understand that using a shared Gift for a purpose other than the intended purpose would be an abuse of trust. By doing so, I (we) understand that my (our) medical bills submitted for sharing will be refused, my (our) membership will be terminated, and I (we) will not be eligible to re-apply.
JK		I (We) understand that my (our) membership account must be current and in good standing, in order to have eligible medical needs shared within the program.
JK		I (We) understand that a portion of my monthly Gifts is used to pay administrative costs of the ministry.
JK		I (We) understand and agree as a CMM member that any controversy or disagreement with CMM will be resolved through Biblically-based mediation or Christian Alternate Dispute Resolution as detailed in the CMM Guidelines. I (We) waive any right to file a lawsuit or claim against Logos Missions, Inc. or its officers, directors, or employees. I (We) will not seek any unpaid medical expenses from Logos Missions, Inc. or its officers, directors, or employees.

By the execution hereof, I as the agent of all the individuals hereof attest that we have initialed, understood and agreed to all of the above statements.

Primary Name	Julie Kim	**Signature / Date**	3/1/18
Spouse Name		**Signature / Date**	

** The full refund of Gift will be made in the only event that the new membership is properly cancelled **on or before the 10th day** of the first month of membership.*

At the present time your plenty will supply what they need, so that in turn their plenty will supply what you need. The goal is equality. 2 Corinthians 8:14

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Recurring Monthly Gift Payment Authorization Form

Schedule your monthly gifts to be automatically deducted from your bank account, or charged to your Visa, MasterCard, or Discover Card. Just complete and sign this form to get started!

Recurring Monthly Gift Giving Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your Monthly Gift is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Monthly Gift Giving Works:

You authorize regularly scheduled charges to your checking account or credit card. You will be charged the amount indicated below for each billing period. A receipt for each Monthly Gift payment will be emailed to you and the charge will appear on your bank statement as "**Logos Missions, Inc.**" or "**Christian Mutual Med-Aid**". You understand that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from CMM.

Please complete the information below:

I, Julie Suhyoung Kim (Full Name),
authorize Christain Mutual Med-Aid (Operated by Logos Missions, Inc.) to charge my credit card or checking account indicated below on the 1st day of each month for my CMM Monthly Gift.

Billing Address 22304 68th PL W

City, State, Zip Mountlake Terrace, WA, 98043

Phone Number 4255020058

E-mail Address julie.suhyoung.kim@gmail.com

CMM MEMBERSHIP INFORMATION

Member Account # _____

Monthly Gift Amount 40.00

CMM Program Level Bronze

CHECKING ACCOUNT

☐ **Checking** *(PLEASE ATTACH VOIDED CHECK)*

Name on Account _____

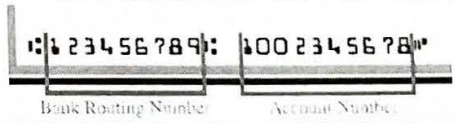
Bank Name _____

Bank Routing # (9-Digits) ☐☐☐☐☐☐☐☐☐

Account Number _____

Bank City/State _____

** EXAMPLE **



CREDIT CARD

☒ **Visa** ☐ **MasterCard** ☐ **Discover**

Cardholder Name Julie S Kim

Card Number 4147 0978 9753 3354

Expiration Date 09/21 CVV Code (3-Digits) 099

Billing Zip Code 98043

Signature _____ **Date** 3/1/2018

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify CMM in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that CMM may at its discretion attempt to process the charge again within 30 days, and agree to an additional $20 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

At the present time, your plants will supply what they need, so that in turn their plants will supply what you need. The