

5235 N. Elston Ave. | Chicago, IL 60630 | Phone 773.777.8889 | Fax 773.777.0695 | www.cmmlogos.org

Membership Number:

Primary Name:

Address1

Address2

RE: Required documents for dependents aged 18-25 (자녀 신청서)

Christian Mutual Med-Aid (hereinafter referred to as CMM) is a not-for-profit Christian health care sharing ministry. We practice our Lord's love by encouraging members to pray for and share medical expenses of our fellow Christians who fall ill and are in need of help with their medical costs.

Under our Guidelines, financial dependents aged 18-25 may be added on their parent's membership account if dependents satisfy membership qualifications, such as acceptance of Jesus Christ as their savior, abstaining from the use of alcohol, tobacco and unlawful drugs, living by Biblical principles and being unmarried. If you are aged 18-25 and intend to add on your parent's membership, please complete and return the following forms like *Health History, Membership Agreement & Checklist of Understanding, Membership Qualifications and Proof of dependent status* (e.g. first page of parent's tax return).

제목: 18-25 세 자녀 등록

CMM 가이드라인에 따르면, 18-25 세까지의 자녀는 부모와 같은 멤버십 어카운트에 추가할 수 있습니다. CMM 의 회원 자격 요건은 예수님을 구주로 영접하고 술, 담배, 마약을 하지 않으며 성경적인 생활을 하고 결혼하지 않은 재정적 부양자녀입니다. 부모의 멤버십에 추가하기 원하는 자녀는 첨부한 서류들을 스스로 작성한 후 서명하여 보내시기 바랍니다.

- *첨부서류:** 1. 회원 자격 요건 (Membership Qualifications) 2. Health History
3. Membership Agreement & Checklist of Understanding Form
4. 재정적 부양가족임을 증명할 수 있는 서류 (예를들면, 부모 텍스보고서의 첫 페이지 사본 등)

Membership Qualifications (회원 자격 요건)

Parent Name		Last Name	First	Middle	MEMB No.	
Adult Child	Last Name		First	Middle		
	Date of Birth		Social Security #		Gender	
	/ /				<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Address		Apt #	City	State	Zip Code
Required	Primary ☎		Secondary ☎		Email Address	
	Select Programs: <input type="checkbox"/> Gold Plus <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze					
	Have you accepted Jesus Christ as your Lord and Savior? 당신은 예수 그리스도가 당신의 구세주이심을 믿습니까? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Please <u>mark</u> the item below: 술, 담배, 불법약물의 과거와 현재 사용 여부를 각각 괄호에 체크 표시하십시오.					
	Current Use			Uses of the Past		
	Alcohol	() Yes	() No	Alcohol	() Yes	() No
Tobacco	() Yes	() No	Tobacco	() Yes	() No	
Illegal Drugs	() Yes	() No	Illegal Drugs	() Yes	() No	

Signature: _____ **Date:** _____

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Health History : 건강확인서

Have you 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. 당신은 아래의 병으로 치료를 받았거나 수술을 받은 적이 있습니까? 받은 적이 있으면 Y, 없으면 N에 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 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 (기독교의료상조회는 본회가 작성, 수령, 관리하는 귀하의 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.)								CHILD 본인 *
Have you had symptoms, treatments or diagnoses of any doctor during the past 5 years (Including without limitation regular check-ups)? 본인은 지난 5년간 건강 상태와 관련해 증상이 있거나, 치료 또는 진단받은 적이 있습니까 (정기검진 포함)?								Y / N
Have you had symptoms, treatments or diagnoses of high blood pressure, diabetes, heart diseases or vascular diseases? 본인은 고혈압, 당뇨병, 심장병, 뇌졸중 및 혈관 질환의 증상이나, 진단 및 치료를 받은 적이 있습니까?								Y / N
Have you had symptoms, treatments or diagnoses of allergies, asthma or respiratory problems? 본인은 알레르기, 천식 및 호흡기 질환의 증상이나, 진단 및 치료를 받은 적이 있습니까?								Y / N
Have you had symptoms, treatments or diagnosed of arthritis, rheumatoid, arthritis, chronic back pain, muscular or skeletal or nervous systems? 본인은 관절염, 류마티스, 척추 및 신경계통, 근/골격계 질환의 증상이나, 진단 및 치료를 받은 적이 있습니까?								Y / N
Have you had symptoms or medical conditions related to eyes, nose, ears, hands, feet? 본인은 눈, 코, 귀, 손, 발 관련 질환의 증상이나, 진단 및 치료를 받은 적이 있습니까?								Y / N
Have you had symptoms or medical conditions related to stomach, liver, colon, kidney or any internal organs? 본인은 위, 간, 대장, 신장 및 장기 관련 질환의 증상이나, 진단 및 치료를 받은 적이 있습니까?								Y / N
Have you had symptoms or medical conditions related to thyroid, tumor or cancer? 본인은 갑상선, 각종 종양 및 암 관련 질환의 증상이나, 진단 및 치료를 치료를 받은 적이 있습니까?								Y / N
Have you had symptoms or medical conditions related to prostate or female reproductive organs? 본인은 전립선 또는 여성 질환과 관련해 증상이 있거나, 치료 또는 진단 받은 적이 있습니까?								Y / N
Have you had congenital diseases or symptoms or other related medical conditions? 본인은 선천적 질환과 관련해 증상이 있거나 치료 또는 진단 받은 적이 있습니까?								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

* Required

* Signature _____

* Date _____

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Membership Agreement & Checklist of Understanding

I understand that a CMM member is a Christian who lives by Biblical teachings and shares one another's burdens according to the biblical teachings of Galatians 6:2.

I understand that CMM is a health care sharing ministry, not a health insurance company. As such, membership in CMM does not constitute a guarantee to pay the medical bills of a participant. I understand that the participant is responsible for payment of his/her own medical bills as a self-pay Patient.

I understand that a participant must abstain from tobacco including any smoking device, illegal drugs, the improper or unauthorized use of prescription medications or OTC medications, and abuse of alcohol. I understand that a participant must only engage in sexual relations within a Biblical Christian marriage.

I understand the monthly Gift to support other participants who are in need is due by the first day of each month.

I understand that the entire eligibility of sharing of the qualifying medical bills will be effective after a 90-day waiting period.

I understand that the eligibility of the submitted medical bills is determined in accordance with the CMM Guidelines.

I understand that the medical expenses for the pre-existing Conditions and the bills occurred prior to the membership will not be shared by CMM.

I understand that I must notify CMM prior to seeking medical services.

I understand that I must register to the medical facilities as an uninsured patient.

I understand that I must request for discounts, fee adjustments, or financial assistance, such as charity care, from all medical providers.

I understand that I must complete a Needs Processing packet and submit itemized bills with proof of payment if already paid for swift processing of submitted bills.

I understand that CMM members are participating in Burden Sharing which the participants may share qualified medical bills in excess of the ministry's \$150,000 lifetime limit per illness.

I understand that the monthly Gift will be adjusted by adding the amount of 0.1 % per dollar shared if the amount of shared bills exceeds \$10,000.

I understand that no legal contract or obligation exists between CMM and the individual participant regarding indemnification or reimbursement of medical bills.

I understand that if the participant received payments for medical bills from other sources, including but not limited to third-party tortfeasors or insurers, the participant shall reimburse the shared fund to CMM. I further understand that the membership will be terminated if the participant misuses the shared fund for medical needs.

I understand that the membership account must be current and in good standing in order to have eligible medical needs shared within the program.

I understand that a portion of the monthly Gift is used for the operating expenses of the organization.

I 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 waive any right to file a lawsuit or claim against Logos Missions, Inc. or its officers, directors, or employees. I will not seek any unpaid medical expenses from Logos Missions, Inc. or its officers, directors, or employees.

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, Christian Mutual Med-Aid, 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.

By signing here, I understood and agreed to all of the above statements.

Member Name *

Signature *

Date *

* Required

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회원 동의서 및 이해 확인서

본인은 성경의 가르침에 따라 생활하는 크리스천이며 기독교의료상조회(이하 'CMM'이라 한다) 회원들이 서로의 짐을 나누어 지는 것을 이해합니다(갈라디아서 6:2).

본인은 CMM이 건강보험회사가 아니라 의료비 나눔 사역임을 이해하며, 의료비 나눔에 동참한 회원들에게 어떤 보장도 주어지지 않는다는 것을 이해합니다. 그 뿐 아니라 CMM은 본인이 거주하는 주의 보험국에서 인증 받거나 보증되지 않음을 이해하며, 지불 청구나 손실은 거주하는 주의 보증 기금에 의해 보호받지 못함을 이해합니다.

본인은 흡연, 불법 약물 복용을 하지 않으며, 처방약 및 기타 약물과 알코올 오남용을 하지 않으며, 비성서적 결혼 생활을 추구하지 않는다는 사실을 확인합니다.

본인은 다른 회원을 돕기 위해 매월 1일까지 회비를 납부해야 함을 이해합니다.

본인은 가입 후 90일간의 대기기간이 있음을 이해합니다.

본인은 제출한 의료비의 지원 여부가 CMM Guidelines에 의해 결정됨을 이해합니다.

본인은 CMM 가입 이전에 발행한 의료비는 지원되지 않음을 이해합니다.

본인은 본인의 의료비 지원 여부 및 CMM의 존재 여부에 관계없이 본인의 의료비에 대한 책임이 본인에게 있음을 이해합니다.

본인은 의료기관을 방문하기 전에 CMM에 보고해야 하는 의무가 있음을 이해합니다.

본인은 의료기관을 방문할 때, Uninsured로 등록해야 한다는 것을 이해합니다.

본인은 할인, 가격 조정 혹은 Charity Care와 같은 재정 지원 프로그램을 의료 기관에 요청해야 함을 이해합니다.

본인은 의료비 지원 신청서 및 자세한 진료비 내역서가 모두 접수 되어야만 의료비 지원 절차가 시작됨을 이해합니다.

본인은 어느 회원이 지원 요청한 의료비가 \$150,000을 초과할 경우, Burden-Sharing을 통해 모든 회원들이 초과한 의료비를 나누어 지원해야 함을 이해합니다.

본인은 \$10,000이상의 의료비를 지원받을 경우, 지원받은 금액의 0.1%가 월 회비에 추가됨을 이해합니다.

본인은 CMM과 회원 간에 의료비 보증이나 의료비 배상에 관한 어떤 법적 계약이나 의무도 존재하지 않음을 이해합니다.

본인은 CMM을 통해 이미 지원 받은 의료비를 보험이나 병원 등 제3의(혹은 다른) 경로를 통해 지원 받았을 경우 CMM에서 지원 받은 금액을 반드시 환불해야 합니다. 이를 환불하지 않을 경우에는 회원 자격이 박탈되며, 재가입이 불가능함을 이해합니다.

본인이 의료비 지원을 받으려면, 회원 자격을 계속 유지해야 하며, 미납된 회비가 없어야 함을 이해합니다.

본인은 월 회비의 일부분이 CMM 운영비로 사용되어 짐을 이해합니다.

CMM의 역할은 회원들로부터 기금을 모으고 가이드라인에 따라 의료비 지원을 돕는 것에 국한됩니다. 신청인은 CMM과 논쟁 또는 의견 충돌이 있을 경우 가이드라인에 명시된 대로 제한없는 크리스천 중재나 크리스천 조정을 포함한 크리스천 대체 분쟁 해결 방법을 통해 해결할 것을 인정하고 동의합니다. 그리고 신청인은 CMM이나 CMM의 임직원을 상대로 법적 소송을 제기할 권리를 완전히 포기할 것을 인정하고 동의합니다. 회비 안내서는 매달 10일에 발송합니다.

아래에 서명함으로써, 본인은 위의 내용을 숙지하였으며, 동의했음을 확인합니다.

회원 이름 *

서명 *

날짜 *

* 필수입력

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