

## Application Form

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

[www.cmmlogos.org](http://www.cmmlogos.org)

<b>CHECK ONE:</b> (해당란에 ✓ 표시하십시오.)		Referred by (소개자 이름): _____	Member ID: _____
<input type="checkbox"/> ONE UNIT (1인) <input type="checkbox"/> TWO UNITS (2인) <input type="checkbox"/> THREE UNITS (3인이상)		<input type="checkbox"/> Friend <input type="checkbox"/> Conference <input type="checkbox"/> Directory <input type="checkbox"/> Internet <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio/TV	
<b>1st</b> (가입자)	<b>SELECT PROGRAM</b> (프로그램을 선택하십시오.):		<input type="checkbox"/> Gold Plus <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze
	Last Name	First	Middle
	Date of Birth / /	Social Security #	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Address		Apt. #
	City	State	Zip Code
Primary ☎:	Secondary ☎:	E-mail Address: _____	
<b>2nd</b> (배우자)	<b>SELECT PROGRAM</b> (프로그램을 선택하십시오.):		<input type="checkbox"/> Gold Plus <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze
	Last Name	First	Middle
	Date of Birth / /	Social Security #	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Primary ☎:		E-mail Address: _____
	<b>AN ADULT DEPENDENT MEMBER AGED FROM 18 TO 25 IS REQUIRED TO SUBMIT THE PROOF OF DEPENDENT QUALIFICATION TO CMM EVERY YEAR.</b> (부양 가족으로 등록된 18세에서 25세 사이의 성인 자녀가 있는 경우는 매년 부양 증명 서류를 CMM에 제출해야 합니다.)		
<b>3rd</b> (자녀)	<b>SELECT PROGRAM</b> (프로그램을 선택하십시오.):		<input type="checkbox"/> Gold Plus <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze
	Last Name	First	Middle
	Date of Birth / /	Social Security #	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	<b>SELECT PROGRAM</b> (프로그램을 선택하십시오.):		<input type="checkbox"/> Gold Plus <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze
	Last Name	First	Middle
Date of Birth / /	Social Security #	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
<b>SELECT PROGRAM</b> (프로그램을 선택하십시오.):		<input type="checkbox"/> Gold Plus <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze	
Last Name	First	Middle	
Date of Birth / /	Social Security #	Gender <input type="checkbox"/> M <input type="checkbox"/> F	

**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 자격 시작일은 소급 적용 되지 않으며, 신청서가 사무실에 접수된 이후에는 변경할 수 없습니다.)

I would like my membership to begin the first day of   /  . I have enclosed my first gift of \$                .  
(Month)      (Year)      (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 _____	Pastor <input type="checkbox"/> 목사	Elder <input type="checkbox"/> 장로	Deacon <input type="checkbox"/> 권사	Member <input type="checkbox"/> 집사
Church Name (출석교회 이름)	Member's Position (회원직분)			
Pastor Name (담임목사) _____	☎ Tel _____			
Church Address _____				

## 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 N에 체크해 주세요. "Yes"라고 대답했다면 아래 참고란에 간단한 설명을 적어 주십시오.

		<b>PRIMARY 본인</b>	<b>SPOUSE 배우자</b>	<b>CHILD 1 자녀1</b>	<b>CHILD 2 자녀2</b>	<b>CHILD 3 자녀3</b>	<b>CHILD 4 자녀4</b>
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 진단 받은 적이 있습니까?(경기검진 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, 뇌졸증, 및 혈관 질환의 증상이나, 진단 및 치료를 받은 적이 있습니까?		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 받은 적이 있습니까?		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 신경통, 근/골격계 질환의 증상이나, 진단 및 치료를 받은 적이 있습니까?		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 받은 적이 있습니까?		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 받은 적이 있습니까?		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 받은 적이 있습니까?		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

<b>Name 이름</b>	<b>Treatment Date 치료일자</b>	<b>Diagnosis   Duration   Results   Tests Performed   Medication   Outcome</b>	<b>Attending Physician's Name, Address and Phone Number 의사이름, 주소 및 전화번호</b>

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 돋는 것에 국한됩니다. 신청인은 CMM과의 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 로고스 선교회의 임직원 또는 에이전트들을 상대로 법적 소송을 제기할 권리와 함께 이를 포기하는 것을 인정하고 동의합니다. 회비 안내서는 매달 10일에 발송합니다.)

By signing here, I certify that I am authorized to complete this application on behalf of my minor children and me as the primary member. By signing here, my spouse and I agree to all terms and conditions of the membership. (본인은 본인을 포함, 18세 미만 자녀를 대신해 가입 신청서를 작성했음을 서명으로 확인합니다. 본인과 본인의 배우자는 모든 회원 약관에 동의함을 서명으로 확인합니다.)

**Signature of Primary** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Spouse** \_\_\_\_\_ **Date** \_\_\_\_\_

5235 N. Elston Ave. | Chicago, IL 60630 | Phone 773.777.8889 | Fax 773.777.0695 | [www.cmmlogos.org](http://www.cmmlogos.org)

### 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

*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)*

Christian Mutual Med-Aid (CMM) is a not-for-profit organization established in 1996 and federally recognized as a 501(c)(3). CMM is a Biblically-based health care sharing ministry through which Christians share God's blessings by sharing the cost of one another's qualifying medical expenses. As such, CMM is not an insurance company and should not be referred to or considered as a substitute for any other type of health or medical insurance.

Last Updated:20181204

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## 회원 동의서 및 이해 확인서

본인은 성경의 가르침에 따라 생활하는 크리스천이며 기독의료상조회(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 돋기 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 돋는 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 권리와 포기할 것을 인정하고 동의합니다. 회비 안내서는 매달 10일에 발송합니다.

**아래에 서명함으로써, 본인은 위의 내용을 숙지하였으며, 동의했음을 확인합니다.**

회원이름 \*

서명 \*

날짜 \*

\* 필수입력

*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)*

Christian Mutual Med-Aid (CMM) is a not-for-profit organization established in 1996 and federally recognized as a 501(c)(3). CMM is a Biblically-based health care sharing ministry through which Christians share God's blessings by sharing the cost of one another's qualifying medical expenses. As such, CMM is not an insurance company and should not be referred to or considered as a substitute for any other type of health or medical insurance.

Last Updated: 20181126

## 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:

<p>I, _____,  <small>(Full Name)</small>          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.</p>	
Billing Address	_____
City, State, Zip	_____
Phone Number	_____
E-mail Address	_____
<b>CMM MEMBERSHIP INFORMATION</b>	
Member Account #	_____
Monthly Gift Amount	_____
CMM Program Level	_____

<b>CHECKING ACCOUNT</b>			
<input type="checkbox"/> <b>Checking</b> <small>(PLEASE ATTACH VOIDED CHECK)</small>			
Name on Account	_____		
Bank Name	_____		
Bank Routing # (9-Digits)	<input type="text"/>		
Account Number	_____		
Bank City/State	_____		
<small>** EXAMPLE **</small> 			
Bank Routing Number	<small>123456789</small>		
Account Number	<small>1002345678</small>		
<b>CREDIT CARD</b>			
<input type="checkbox"/> <b>Visa</b> <input type="checkbox"/> <b>MasterCard</b> <input type="checkbox"/> <b>Discover</b>			
Cardholder Name	_____		
Card Number	_____		
Expiration Date	_____	CVV Code (3-Digits)	_____
Billing Zip Code	_____		

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

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.