Impact Health Sharing

APPLICATION
FOR LEAVING FAMILY
FOR INDIVIDUAL PROGRAM

Programs ***Please print legibly and use black ink.***

Pick your Primary Responsibility Amount*:	I would like to leave my family program for own program. I would like to participate in the following Primary Responsibility Amount (PRA): ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000
I have read the Impact Guidelines:	☐ Yes (If you have not read the Guidelines, you must read them online at ImpactHealthSharing.com
I understand that Impact is not insurance:	☐ Yes
	*If you haven't already done so, visit ImpactHealthSharing.com/prices where you will be asked to enter your birthday to see the monthly share amount for each Primary Responsibility Amount.

Parent/Guardian Information

Last Name	First Name	Membership ID

Applicant Information

Last Name	First Name		Middle Initial
Address	City	State	Zip
Primary Phone *(a cell phone # enables us to provide you with text notifications including password resets)*			
Email	Marital Status: ☐ Married ☐ Single ☐ Date of Marriage:		
VITAL STATS OF APPLICANT	Social Security Number	Birthday (mm/dd/yy)	Age
Height	Weight	Sex ☐ Male ☐ Female	

ATTENTION: Impact Health Sharing is a 501(c)3 not-for-profi t organization that facilitates the sharing of medical bills among its Members. Impact is NOT insurance. There is no guarantee of payment or promise to pay. Impact is not a discount card or program. Impact is not subject to the regulatory requirements or consumer protections of your particular State's Insurance Code or Statutes.