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Thank you for your interest in becoming a member of CHS.

We welcome the opportunity to review your application. In order to fully evaluate it, the following information is required. Your application will not be accepted if it is incomplete.

The CHS Staff

**PLEASE INITIAL EACH ITEM AS YOU ATTACH IT. SIGN AND DATE THE BOTTOM OF THIS SHEET. IT IS POSSIBLE THAT YOUR APPLICATION INFORMATION WILL CAUSE US TO HAVE QUESTIONS. PLEASE EXPECT A PHONE CALL FROM OUR OFFICE IF ANY QUESTIONS ARISE. APPLICATIONS WITH MISSING MATERIALS OR UNANSWERED QUESTIONS ARE DISCARDED AFTER 10 DAYS.**

1. \_\_\_\_\_ Proof of residency (Rental agreement, Mortgage Bill or Note from Landlord)
2. \_\_\_\_\_ Copy of your complete IRS return for the most recent year, **2010, 1040 FORM AND ALL REQUIRED SCHEDULES**  
(if submitting application after March 1, 2012: 2011 IRS Forms are required)
3. \_\_\_\_\_ Copies of most recent **SIX (6) CONSECUTIVE WEEKS** paycheck stubs
4. \_\_\_\_\_ Insurance Verification Form if working (See form to download)
5. \_\_\_\_\_ Proof of ALL/ANY income (Social Security, Unemployment Determination, Child Support, Alimony, Worker Compensation, Pension, Disability or Other)
6. \_\_\_\_\_ Your most recent **complete** bank statements (checking and savings)  
– **All pages for all accounts including money market, ING or other**
7. \_\_\_\_\_ Copies of **ALL BILLS** for the household – **See Section 5**
8. \_\_\_\_\_ Copy of Divorce or Separation Agreement if applicable

**IF YOU ARE SELF-EMPLOYED, THE FOLLOWING IS ALSO REQUIRED:**

1. \_\_\_\_\_ **Complete copies of personal and business bank statements for the most recent 3 months**
2. \_\_\_\_\_ **Complete copies (including all attachments) of business and personal tax returns**

**ALL REQUIRED INFORMATION HAS BEEN PROVIDED.**

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

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

COMPLETE THE FOLLOWING. DO NOT LEAVE BLANK SECTIONS. THE APPLICATION WILL BE RETURNED TO YOU.

Section #1 - General Information:

Applicant Name: Social Security #:

Address:

Telephone #: Cell Phone #:

E-mail Address:

Emergency Contact:

Relationship: Telephone #:

How long have you lived at this address:

Date of Birth: Male Female Marital Status (circle) M S D Sep W

Are you a veteran? Are you eligible for or receiving VA benefits of any kind?

If yes to above, please provide documentation explaining your VA benefits.

Dependent/Spouse Information:

Table with 3 columns: Name, Social Security #, Date of Birth

Please list the names of all other individuals residing in your household:

Table with 3 columns: Name, Relationship, Date of Birth

Section #2 - Employment History:

Table with 4 columns: Employer, Phone, Dates, Salary

Applicant: Spouse/Partner:

Is health insurance offered through employer?

Table with 4 columns: Previous Employer, Phone, Dates, Salary

Applicant: Spouse/Partner:

**Section #3 - Property:**

Do you own your home? \_\_\_\_\_ Monthly Payment: \$ \_\_\_\_\_ Taxes: \$ \_\_\_\_\_

Is this your primary residence? \_\_\_\_\_ Do you own any other property? \_\_\_\_\_

Do you receive any rental income? \_\_\_\_\_ Amt.: \$ \_\_\_\_\_

Please list type of property: \_\_\_\_\_ Value: \_\_\_\_\_ Monthly Payment: \$ \_\_\_\_\_

Have you sold any property in the last year? \_\_\_\_\_

Vehicles:	Make/Year	Estimated Value	Monthly Payment

Investments or assets: Current value of CD: \$ \_\_\_\_\_, Stocks/Bonds \$ \_\_\_\_\_, IRA \$ \_\_\_\_\_,

Please list any other assets: \_\_\_\_\_

**Section #4 - Other Income:**

Disability \$ \_\_\_\_\_, Unemployment \$ \_\_\_\_\_, Social Security \$ \_\_\_\_\_,

Child Support \$ \_\_\_\_\_ Food Stamps \$ \_\_\_\_\_, Fuel Assistance \$ \_\_\_\_\_,

Housing \$ \_\_\_\_\_, Worker Compensation \$ \_\_\_\_\_, Alimony \$ \_\_\_\_\_,

Income from Trust \$ \_\_\_\_\_, Other \$ \_\_\_\_\_ (Please note how often income is received)

If you are receiving a disability income, have you applied for long term disability, APTD, etc. \_\_\_\_\_

What is the current status of your application? \_\_\_\_\_

Are you receiving Worker Compensation benefits of any kind? \_\_\_\_\_

Does Worker Compensation pay for medical bills or prescriptions related to an injury you have sustained? \_\_\_\_\_

If yes, please explain in detail

\_\_\_\_\_  
\_\_\_\_\_

**Section #5 - Expenses:**

**Credit Cards: (provide copies of all bills)**

Card	Balance Due	Monthly Payment

**Medical Expenses: (provide copies of all outstanding bills)**

Provider	Date of Service	Balance Due	Monthly Payment

**Other Monthly Expenses: (provide copies of all bills)** Rent \$ \_\_\_\_\_, Heat \$ \_\_\_\_\_,  
 Propane \$ \_\_\_\_\_ Water \$ \_\_\_\_\_, Phone \$ \_\_\_\_\_, Cell Phone \$ \_\_\_\_\_,  
 Electricity \$ \_\_\_\_\_, Insurances (all) \$ \_\_\_\_\_, Cable/Internet \$ \_\_\_\_\_,  
 Groceries \$ \_\_\_\_\_, Gasoline \$ \_\_\_\_\_, Child Support \$ \_\_\_\_\_,  
 Other \$ \_\_\_\_\_ (Please list \_\_\_\_\_)

Do you share monthly expenses with any other member of your household? \_\_\_\_\_

**Section #6 - Additional Information:**

How did you hear about CHS? \_\_\_\_\_ Have you ever been a member? \_\_\_\_\_

Are you or any members of your household covered by health insurance of any kind including NH Medicaid, NH Healthy Kids or Medicare? \_\_\_\_\_

If yes, please list names and coverage: \_\_\_\_\_

When were you last seen by a physician? \_\_\_\_\_

Do you currently have a Primary Care Physician? \_\_\_\_\_ Name: \_\_\_\_\_

Please list the names of the medications that you currently take: \_\_\_\_\_

Who wrote the prescriptions? (prescribing physician) \_\_\_\_\_

**In signing this application I am verifying that the information contained in it is true and accurate. I further understand that my membership will be in jeopardy if I have omitted information or provided information that is false. Further, I give CHS permission to contact, my employer, creditors, physician and other individuals, organizations or entities who may have information necessary to evaluate this application.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date