

HealthPartners Enrollment Form



Member Name _____
 Member ID# _____ Grp ID# _____
 Date of Birth ____/____/____ Gender: M F
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____
 E-Mail _____

For Fitness Center Use ONLY: **New Enrollment** **Change in Insurance/Employer Info** **Change in Bank Account Info**

Fitness Center Name _____ Club # _____
 Fitness Center Member _____ Monthly Average Dues \$ _____

Member Initials:

- _____ A. I understand each adult must work out at the fitness facility named above eight (8) to twelve (12) days per calendar month to receive the up to \$20 credit. I also understand my workout must happen inside the facility and/or within that facility's supervised programming. Each adult can qualify for a monthly credit of up to \$20; only 1 workout per day is counted
- _____ B. I understand there will be a period of time between the completed month and the applied credit. Example: work out 8 days in January, verified in February, credit applied to account by the end of February.
- _____ C. I understand the reimbursements issued cannot exceed the total monthly membership for the month the credit is applied.
- _____ D. I understand that canceling my membership will result in forfeiture of any unapplied credits.
- _____ E. I understand that it is my responsibility to ensure that my visit is recorded at the time of my workout.

Signature _____ Date ____/____/____

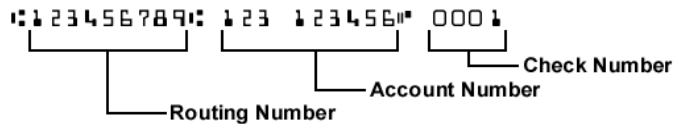
Member Authorization of Credit:

Type of Account:

- Checking (attach voided check below)**
- Savings (attach savings deposit slip below)**

Routing Number: _____

Account Number _____



Example of HealthPartners Card



I authorize the above fitness center to process credit entries to the account indicated above. This authorization will remain in effect until I notify the above fitness center to discontinue the electronic deposits of funds.

Signature _____ Date ____/____/____

PLEASE ATTACH VOIDED CHECK HERE.