HealthPartners
Enrollment Form

NIHCA
National Independent Health Club Association

HealthPartners®

Member Name _____

Member ID# _____ Grp ID# _____

Date of Birth _____/_____/_____ Gender: ☐☐

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 _____/_____/_____