

**Medica**  
**Enrollment Form**



Member Name \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Grp ID# \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

<b>For Fitness Center Use ONLY:</b> <input type="checkbox"/> <b>New Enrollment</b> <input type="checkbox"/> <b>Change in Insurance/Employer Info</b> <input type="checkbox"/> <b>Change in Bank Account Info</b>	
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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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