Fitness Center Reimbursement Enrollment Form

SANFORD HEALTH PLAN

Member Name (as it appears on your ID card) _____ ☐ Subscriber ☐ Spouse

Date of Birth _____ / _____ /_____ Gender: ☐ M ☐ F E-Mail _____

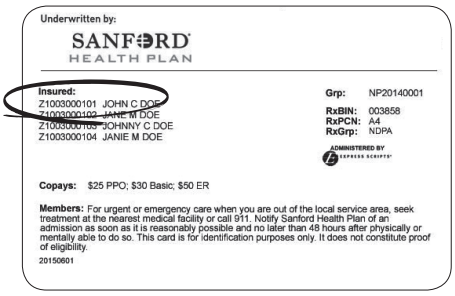
Address _____

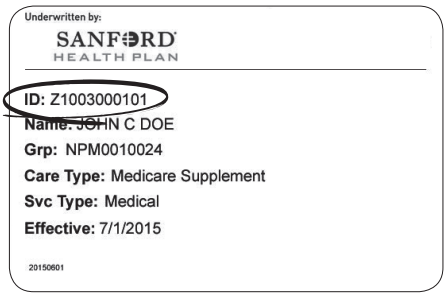
City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Insured Member ID #: _____

Example of Sanford Health Plan ID Cards


Underwritten by:
SANFORD HEALTH PLAN
Insured:
Z1003000101 JOHN C DOE
Z1003000102 JANE M DOE
Z1003000103 JOHNNY C DOE
Z1003000104 JANIE M DOE
Grp: NP20140001
RxBIN: 003858
RxPCN: A4
RxGrp: NDPA
ADMINISTERED BY EXPRESS SCRIPTS
Copays: $25 PPO; $30 Basic; $50 ER
Members: For urgent or emergency care when you are out of the local service area, seek treatment at the nearest medical facility or call 911. Notify Sanford Health Plan of an admission as soon as it is reasonably possible and no later than 48 hours after physically or mentally able to do so. This card is for identification purposes only. It does not constitute proof of eligibility.
20150601


Underwritten by:
SANFORD HEALTH PLAN
ID: Z1003000101
Name: JOHN C DOE
Grp: NPM0010024
Care Type: Medicare Supplement
Svc Type: Medical
Effective: 7/1/2015
20150601

For Fitness Center Use ONLY:

☐ New Enrollment ☐ Change in Bank Account Info
☐ Change in Insurance/Employer Info

Fitness Center Name _____

Fitness Center Member _____

Club # _____

Monthly Average Dues $ _____

Member Initials:

_____ A. I understand I must work out at the fitness facility named above twelve (12) * days per calendar month to receive up to a $20 reimbursement. I also understand my workout must happen inside the facility and/or within that facility's supervised programming. The insured member and the insured member's covered spouse may participate in the program. Each adult can qualify for a monthly reimbursement; only 1 workout per day is counted.

_____ B. I understand there will be a period of time between the completed month and the applied reimbursement. Example: work out 12 days in January, verified in February, reimbursement applied to account by the end of February.

_____ C. I understand the reimbursements issued cannot exceed the total monthly membership for the month the reimbursement is applied.

_____ D. I understand that canceling my membership will result in forfeiture of any unapplied reimbursements. All applied reimbursements will be credited to the out-going member(s).

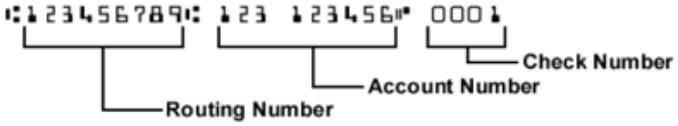
_____ E. I understand that it is my responsibility to ensure that my visit is recorded at the time of my workout.

Signature _____ Date _____ / _____/ _____

Member Authorization of Credit:

Type of Account: ☐ Checking ***(attach voided check below)*** ☐ Savings ***(attach savings deposit slip below)***

Routing Number: _____ Account Number: _____



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.

IMPORTANT: A photocopy of the Sanford Health Plan ID card is required with this enrollment form. If at any time your Sanford Health Plan card information changes, please update the fitness center to ensure credit application. Thank you.

NIHCA
National Independent Health Club Association