

Sanford Health Employee Fitness Center Reimbursement Enrollment Form



Enrollment is for (check one): ☐ Employee ☐ Spouse (complete a separate form for employee and spouse)

Employee/Spouse Name (as it appears in One Source/Workday) _____
Date of Birth ____ / ____ / ____ Gender: ☐ M ☐ F E-Mail _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Employee ID # (from One Source/Workday): _____ Include an "S" after the ID for spousal enrollment

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 ____ / ____ / ____

For Fitness Center Use ONLY:

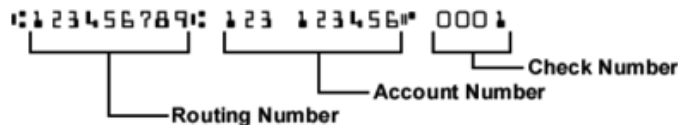
☐ New Enrollment ☐ Change in Bank Account Info ☐ Change in Insurance/Employer Info

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

Member Authorization of Credit:

Type of Account: ☐ Checking ☐ Savings

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 ____ / ____ / ____

RETURN COMPLETED FORM TO YOUR HOME FITNESS CENTER.
YOUR HOME FITNESS CENTER WILL SUBMIT THE INFORMATION TO NIHCA.

NIHCA
National Independent Health Club Association