Dakota County
Fitness Center Reimbursement
Enrollment Form

Enrollment (check one): ☐ Employee ☐Spouse **or** Adult Child (complete a separate form for each member)

Employee/Spouse Name _____

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

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employee ID # (Person number):_____ Add an "**S**" after the ID for **S**pouse or a "**C**" for Adult **C**hild

Member Initials:

_____ A. I understand I must work out at the fitness facility named below **ten** (**10**) * 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/child (18 years of age or older) 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 10 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 (Circle one)***:***

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

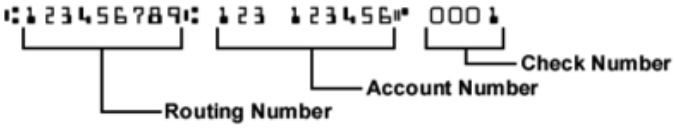
Fitness Center Name _____ Club # _____

Member Name_____ Member's Barcode _____ 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