Blue Cross Blue Shield of MN
Enrollment Form

NIHCA
National Independent Health Club Association

BlueCross BlueShield of Minnesota
An Independent Licensee of the Blue Cross and Blue Shield Association

Member Name _____

Group # _____ Subscriber ID # _____ (up to 15 Characters) Dependent ID # _____ (if applicable)

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

Address _____

City _____State_____ Zip _____

Home Phone _____ Work Phone _____

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 I must work out at the fitness facility named above twelve **(12)** * days per calendar month to receive up to a $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. * Some plans, including self-insured and service co-ops, may require only eight **(8)** visits per month depending on health plan design.

_____ B. I understand there will be a period of time between the completed month and the applied credit. Example: work out **12** 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. All applied credits will be reimbursed 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: _____

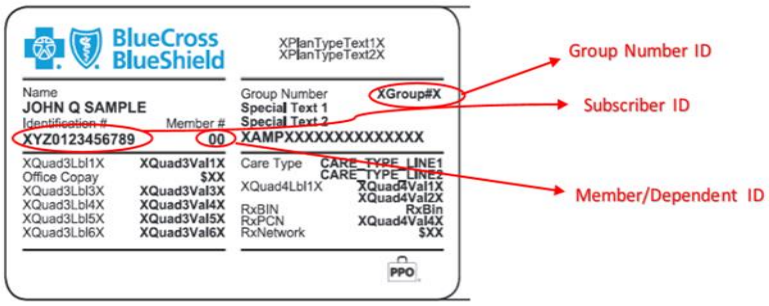
Account Number _____

⑆123456789⑆ 123 123456⑈ 0001

Routing Number — Account Number — Check Number

An Example of a BCBS of MN Medical ID Card

Sample Card with a Member/Dependent ID



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 BCBS of MN medical ID card is required with this enrollment form. If at any time your BCBS of MN medical card information changes, please update the fitness center to ensure credit application. Thank you.