BlueCross BlueShield of North Dakota
An independent licensee of the Blue Cross & Blue Shield Association

NIHCA
National Independent Health Club Association

Enrollment Form

Member Name _____ ❑ Subscriber or ❑ Spouse

Health Plan ID# _____ **OR** Wellness ID# _____

Date of Birth ____ /____ /____ Gender: ❑ Male ❑ Female Email _____

Address _____

City _____ State _____ Zip _____

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. A maximum of two qualifying adults per household may participate in the program. Each adult can qualify for a month credit of up to $20; only 1 workout per day is counted.

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

_____ C. 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.

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

_____ E. I understand that cancelling my membership will result in forfeiture of any unapplied credits. All applied credits will be reimbursed to the out-going member(s).

Signature _____ Date _____ / _____ / _____

Member Authorization of Credit:

Type of Account:

❑ Checking **(attach voided check below)**

❑ Savings **(attach savings deposit slip below)**

Routing Number _____

Account Number _____

⑆000067894⑆ 123456789 0145

Routing Number **Account Number** **Check Number**

Example of BCBSND Medical ID Cards:

Your BCBSND Wellness ID number is W123456789

This is your ID# if you are not covered by a BCBSND Health Plan.

I authorize the above fitness center and Vanco Services, LLC 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 _____ / _____ / _____

Attach voided check or savings deposit slip HERE

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