

Health Club Credit Program



Enrollment Form

Fitness Center Name _____ Club # _____

City _____ State _____ Zip _____

Fitness Center Enrollment Date _____ Monthly Dues \$ _____

Authorization Type: New Authorization Change Account Information Change Insurance Information

First Name _____ Last Name _____ MI _____

BCBSND Health Plan ID Number (12 characters including alpha prefix)

OR

BCBSND Wellness ID Number **W** (10 characters including alpha prefix)

Gender M F Date of Birth _____ / _____ / _____


Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ E-mail _____

Initial

- _____ A. I understand I must work out 12 days or more per calendar month to receive a monthly credit of up to \$20 toward the health center membership fee. A maximum of two qualifying adults per household may participate in this program.
- _____ 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: January workout days are verified in February, and the credit is applied to the fitness center account in March.
- _____ D. I understand the reimbursements issued cannot exceed the total monthly membership for the month the credit is applied.
- _____ E. I understand that canceling my membership will result in forfeiture of any unapplied credits.
- _____ F. If your BCBSND eligibility changes, please let your health center staff know. Please contact BCBSND as it may affect your wellness program credit eligibility.



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

Medical and Rx Benefits
RxBIN 610455
RxPCN NDBCS

ID **YQA999999999** → This is your Health Plan ID #

Name JANE DOE
OFFICE VISIT COPAY \$25
EMERGENCY ROOM COPAY \$75
ADDITIONAL COPAYS MAY APPLY

or

Your BCBSND
Wellness ID number is
W123456789

This is your ID # if you are not covered by a BCBSND health plan.

Signature _____ Date _____