Avera Health Fitness Center Incentive Enrollment Form

Avera

NIHCA
National Independent Health Club Association

Member Name (First, Middle Initial, Last) _____

Member ID#_____ Group # _____

Date of Birth _____/_____ /_____ E-Mail _____

Address _____

City _____ State_____ Zip _____

Cell _____ Work Phone _____

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

Sample Card of Eligible Member

Avera Employee Health Plan

Avera Health Plans Benefit Administrators

Subscriber: John Doe
Group: AVERA MCKENNAN
Member: Jane Doe

Subscriber #: 99123456781
Group #: AH0501
Member #: 99123456782

High Deductible Health Plan
In Network: XXXX Deduct; XX/XX Coinsurance

RXBIN: XXXX
RXPCN: XXX
RXGRP: XXXXX

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 eight **(8)** 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. The Avera employee and/or the employees spouse may participate in the program; only 1 workout per day is counted per person.

_____ B. I understand there will be a period of time between the completed month and the applied credit. Example: Member works out **8** 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 fitness center membership may 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.

I understand the above statements and 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 deposit of funds.

Signature _____ Date _____ /_____ /_____

PLEASE ATTACH VOIDED CHECK HERE.

IMPORTANT: If at any time your information changes, please update the fitness center or go online to NIHCArewards.org to ensure your profile is accurate.