



Fitness Club Enrollment Form

UCare ID Number					
Name (Exactly as it appears on you	r UCare member I	D card)			
First	Last				MI
Date of Birth (Required)		Daytime Phone			
Street Address				Suite/Apt.	
City	State		ZIP		

Member Initials

- I understand that there is a limit of one, maximum \$20 monthly credit per member. I also understand my workout must happen inside the facility and/or within the facility's supervised programming.
- _____ I understand the reimbursements issued cannot exceed the total monthly membership for the month the credit is applied.
- I understand there will be a period of time between the completed month and the applied credit. Example: work out in January, verified in February, credit applied to account by the end of March.
- _____ I understand that canceling my membership will result in forfeiture of any unapplied credits.
- _____ I understand that I may have a visit requirement and it is my responsibility to ensure my visit is recorded at the time of my workout.

Signature	Date / /
Member Authorization of Credit Account type: Checking (attach voided check) Savings (attach savings deposit slip)	Check Number
Routing Number	Account Number

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 fitness center to discontinue the electronic deposits of funds.

Signature _____

Date _____ /_____ /_____

UCare Minnesota and UCare Health, Inc. are Medicare Advantage plans with a Medicare contract. Enrollment in UCare Minnesota and UCare Health, Inc. depends on contract renewal.

– Over –

For Fitness Center Use ONLY

 \Box New enrollment \Box Change in insurance \Box Change in bank account information

Fitness Center Name	Club #
Fitness Center Member	Monthly Average Dues \$
UCare Member ID #	

Examples of UCare Member ID Cards

Eligible UCare plans include:

UCare for Seniors, UCare Choices, Fairview UCare Choices, MinnesotaCare, and PMAP (Medical Assistance)

Pare ucare.org	UCAREChoices Vare
Issuer: 80840 D: 01234567899	Issuer: 80840 ucare.org
Name: JOHN Q DOE	ID: 12345678900 Name: JOHN O DOE
DOB: mm/dd/yyyy	Name: JOHN Q DOE
Rx BIN: 003858 Rx PCN: MD Rx Grp: MNUA RxID: 01234567899 Svc Type: Medical/Dental Group Number: xxxxxx	RxBIN: 003858 RxPCN: A4 RxGrp: L4NA Care Type: UCare Choices Bronze SVC Type: Medical
Care Type: UCare for Seniors Classic	
12459 002 MedicareR	UCare Choices Network
Coverage Year 2015 Prescription Drug Coverage X	Coverage Year 2015 Issued: 11/15/2014
Pate ucare.org	Wate ucare.org
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issuer: 80840 D: 01234567899 PMI#: 123456 Name: JOHN Q DOE DOB: dd/mm/yyyy Rx BIN: 003858 Rx PCN: MA Rx Grp: L58A RxID: 01234567899 Svc Type: Medical/Dental Group Number: xxxxxx	Issuer: 80840 ID: 01234567899 PMI#: 123456 Name: JOHN Q DOE DOB: mm/dd/yyyy Rx BIN: 003858 Rx PCN: MA Rx Grp: L58A RxID: 01234567899 Svc Type: Medical/Dental Group Number: xxxxxx Care Type: UCare MA

Attention. If you need free help interpreting this document, call UCare at 612-676-3200 or toll free at 1-800-203-7225.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកម្មែបឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមឈេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

They us two zoo nyeem. Yog hais tias koj xay tau key pab txhais lus rau tsab ntaub ntawy no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ີ ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທີງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону. .B3-0005 (3-13)

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba. Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

This information is available in other forms to people with disabilities by calling: 612-676-3200 (voice) or toll free at 1-800-203-7225 (voice), 612-676-6810 (TTY) or toll free at 1-800-688-2534 (TTY); or through the Minnesota Relay at 711 or toll free direct access at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.