BluePrint for Health™ fitness discounts Enrollment Form

ES _____

Fitness Center Name _____

Address _____

City, State, Zip _____

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

Type of Authorization: ❑ New Authorization ❑ Change in Account Information ❑ Change in Insurance Information

First Name _____ Last Name _____ Middle Initial _____

BlueCross Dependent I.D.# _____ BlueCross Subscriber ID #_____

BlueCrossGroup #_____ - _____ Date of Birth _____ /_____ /_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Email _____

Fitness Center Member # _____ Monthly Fitness Center Dues $_____

Date Enrolled in Fitness Center Membership _____ /_____ /_____

Type of Account: ❑ Checking **(attach voided check below)**
❑ Savings **(attach savings deposit slip below)**

Routing Number: _____
Located at the bottom of the check between the symbols |: |:

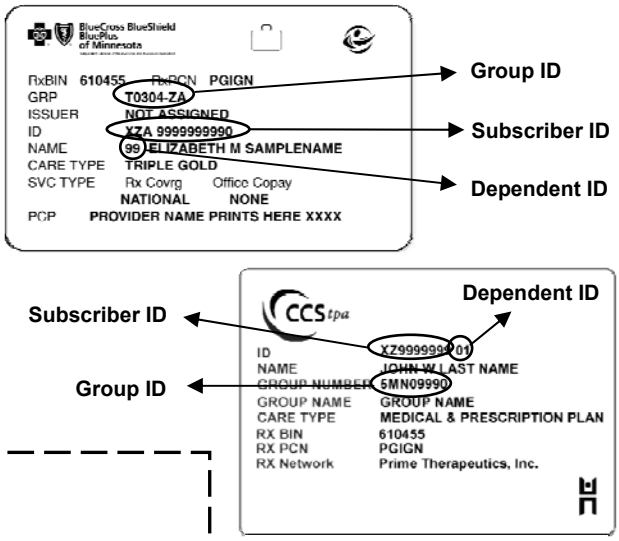
Account Number _____

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 above fitness center to discontinue the electronic deposit of funds.

Signature _____

Date _____ /_____ /_____

PLEASE ATTACH VALID INSURANCE CARD HERE.



PLEASE ATTACH VOIDED CHECK HERE.

VANCO SERVICES

***e.service*® Fitness Rewards®**

Please initial the following:

___ **A.** I understand each adult must work out twelve (12)* days per calendar month to receive the $20 credit towards the fitness center membership fee. Each adult can qualify for a $20 monthly reimbursement towards the membership fee. A maximum of two qualifying adults per household may participate in this program.

___ **B.** I understand there will be a period of time between the completed month and the applied reimbursement. Example: work out twelve days in January, verified in February, reimbursement applied in March.

___ **C.** I understand the reimbursements issued cannot exceed the total monthly membership for the month the reimbursement is applied.

___ **D.** I understand that canceling my membership will result in forfeiture of any unapplied reimbursements.

___ **E.** I understand that it is each adult's responsibility to ensure that their visit is recorded at the time of their workout.

* Some employers' plans may be at eight visits per month, check with your employer for details.