Member Enrollment Form 1 of 2

Member & Program Information

All programs require that each member show proof of eligibility and completes their own form to enroll, even when sharing a joint policy or membership. *Additional forms may be required by health plan and may be requested at any time for completion. Failure to complete form or inaccurate information could be cause for rejection or suspension of benefits.

Member Information (Each member must complete their own form).

Member's First Name: _____ Member's Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Gender: M / F DOB: _____

Program Information

Benefit Provider's Name: _____

Identification Number: _____

Group Number (if applicable): _____ Sub ID (if applicable): _____

A. *I am an eligible member that qualifies for this program, and understand that I am solely responsible for understanding the specific guidelines, restrictions and responsibilities for participating in this program as outlined by my program provider.*
B. *I understand that each enrolled adult must visit this facility a certain number of **d**ays each calendar month, and that it is my responsibility to ensure these visits are recorded at the facility. This monetary incentive and visit requirement is determined by my health plan/employer group and may be changed with notification from that organization.*
C. *I understand that there will be approximately a two-month lag time between the time I complete the visits and the month I receive the reimbursement.*
D. *I understand that the reimbursements issued cannot exceed the total monthly membership for the month the credit is applied.*

Signature: _____ **Date:** _____

Make a copy of the insurance card, activation letter or other proof of eligibility here.

Club Personnel: Please keep these records in a safe secure location. Do not fax, email, or mail them to Healthy Contributions. All information should be destroyed upon termination of membership.

Member Enrollment Form 2 of 2

Deposit Information

Member: Please fill out this section and provide a copy of a voided check to ensure that data entry of numbers will be accurate. For your own protection, **do not use a deposit/withdrawal slip** as this often displays different information than the actual account.

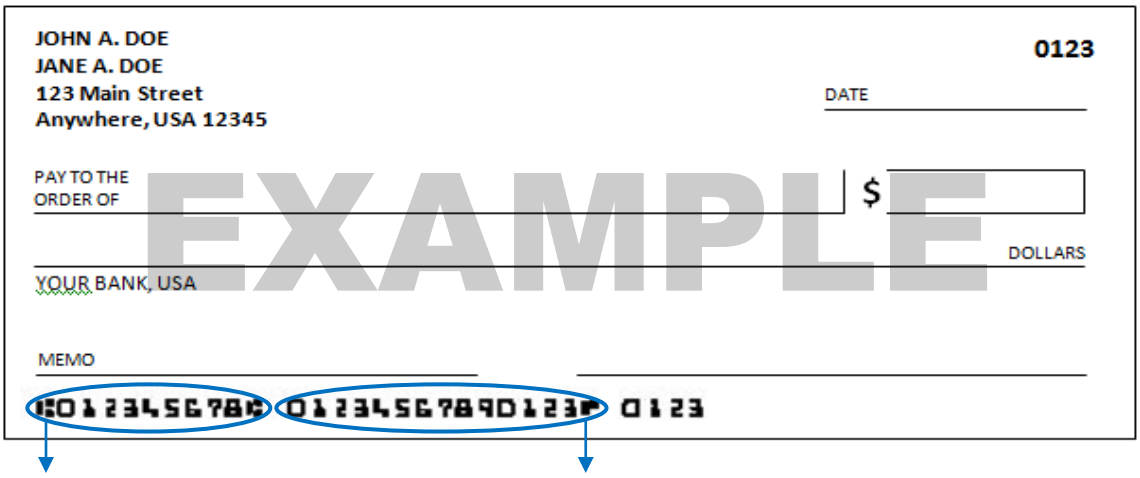
Direct Deposit Information of Member – Please check one option below:

Electronic Funds Transfer: ☐ Checking ☐ Savings

Name on Account: _____

Financial Institution: _____

YOU MAY PASTE A VOIDED CHECK BELOW OVER THE EXAMPLE CHECK PROVIDED



Routing Number: ☐☐☐☐☐☐☐☐☐ **Account Number:** _____

(Must be 9 digits, cannot begin with a "5")

I authorize Healthy Contributions to initiate automatic deposits to my account at the financial institution indicated above. Further, I agree to not hold Healthy Contributions responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds into my account. If funds are deposited in error, I understand that a retraction may occur. This agreement will remain in effect until Healthy Contributions receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to Healthy Contributions.

Signature: _____ **Date:** _____

Club Personnel: Please keep these records in a safe secure location. Do not fax, email, or mail them to Healthy Contributions. All information should be destroyed upon termination of membership.