Blue Cross Blue Shield of MN Enrollment Form



National Independent Health Club Association



of Minnesota

Group # Sub	oscriber ID #	(up to 15 0	Characters) Dependent ID #	(if applicable)
Date of Birth/	_/ Gender: M F E-Mail			
Address				
City	Sta	te Zip		
Home Phone	Work Phon	e		
For Fitness Center Use ONLY:	New Enrollment Change in I	nsurance/Employer Info	Change in Bank Account Info	
Fitness Center Name			Club #	
Fitness Center Member			Monthly Average Dues \$	

Member Initials:

Member Name ____

A. I understand I must work out at the fitness facility named above twelve (12) * 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. Each adult can qualify for a monthly credit of up to \$20; only 1 workout per day is counted. * Some plans, including self-insured and service co-ops, may require only eight (8) visits per month depending on health plan design.

_____B. I understand there will be a period of time between the completed month and the applied credit. Example: work out **12** 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 membership will 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.

Signature	Date / /	
•		

Member Authorization of Credit:

Type of Account:

□ Checking (attach voided check below)

□ Savings (attach savings deposit slip below)

Routing Number: _____

Account	Number			
	56789:	123	123456	0001
				Check Number
				unt Number
	Rou	ting Nu	mber	

An Example of a BCBS of MN Medical ID Card

BlueCross BlueShield		Group Number ID
Name JOHN Q SAMPLE Identification # Member XYZ0123456789 0	Group Number Special Text 1 # Special Text 2 XAMPXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Subscriber ID
XQuad3Lbl1X XQuad3Val1 Office Copay \$X XQuad3Lbl3X XQuad3Val3 XQuad3Lbl4X XQuad3Val4 XQuad3Lbl5X XQuad3Val4 XQuad3Lbl5X XQuad3Val6 XQuad3Lbl5X XQuad3Val6	X CARE TYPE LINE2 X XQuad4Lbl1X XQuad4Val1X X RxBIN XQuad4Val2X X RxPCN XQuad4Val4X	Member/Dependent ID

Sample Card with a Member/Dependent ID

I 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 deposits of funds.

Signature ______ Date ____/____/____

IMPORTANT: A photocopy of the BCBS of MN medical ID card is required with this enrollment form. If at any time your BCBS of MN medical card information changes, please update the fitness center to ensure credit application. Thank you.