

BluePrint for Health[®] fitness discounts Enrollment Form



BlueCross BlueShield of Minnesota

An Independent Licensee of the Blue Cross and Blue Shield Association

ES _____ Fitness Center Name _____
 Address _____
 City, State, Zip _____

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

First Name _____ Last Name _____ Middle Initial _____

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

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

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

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 | : |:

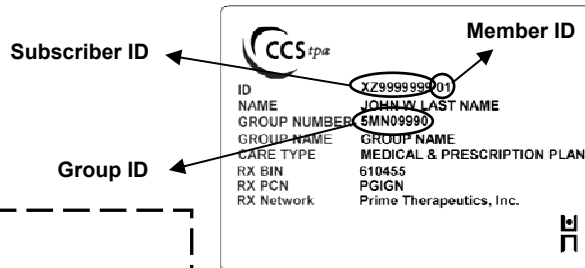
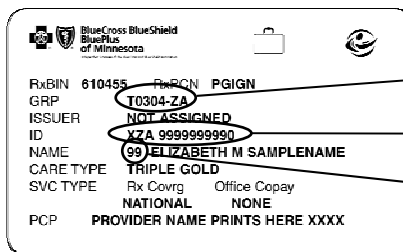
Account Number _____

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.

Fax to:
 Vanco Services, LLC
 952-983-8665



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 to the March bank or credit card debit.
- ___ 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 including self-insured and service co-ops, depending on health plan design.