



Partnering with



**BE FIT Exercise Reward Program**  
**Member Enrollment Form**

Name of South Country Health Alliance (SCHA) Member: \_\_\_\_\_

**SCHA Member ID#:** \_\_\_\_\_

Gender: M F Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

Fitness Center Name _____ Club # _____
Monthly average dues _____

Initial:

- \_\_\_\_\_ A. I understand I must work out at the fitness facility named above eight (8) days per calendar month to receive the \$20 credit towards the fitness center membership fee. I also understand my workout must happen inside the facility and /or within that facilities supervised programming. I can qualify for a \$20 monthly credit towards the membership fee.
- \_\_\_\_\_ B. I understand there will be a period of time between the completed month and the applied credit. Example: work out 8 days in January, verified in February, credit applied to fitness center account in March.
- \_\_\_\_\_ 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.
- \_\_\_\_\_ E. I understand that it is my responsibility to ensure that my visit is recorded at the time of my workout.

Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>Office Use Only</b>	
New Member	_____
Existing Member	_____
Date:	_____

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

**South Country Health Alliance: 1-866-567-7242**

Attention. If you want free help translating this information, call the above number.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຕາມເລກໂທທີ່ຢູ່ຂ້າງເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

183-0001 (1-866)

This information is available in other forms to people with disabilities by calling SCHHA at 1-866-567-7242 (toll free), or 1-877-824-5611 (TTY), or 711, or through the Minnesota Relay Service at 1-877-627-3848 (speech to speech relay service).