

# PreferredOne

Fitness Center Name \_\_\_\_\_

Address \_\_\_\_\_

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

## IMPORTANT:

You must verify eligibility with PreferredOne before completing this form.

### Type of Authorization:

New Authorization     Change in Account Information     Change in Insurance Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Account ID \_\_\_\_\_ Member ID \_\_\_\_\_

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 |:**

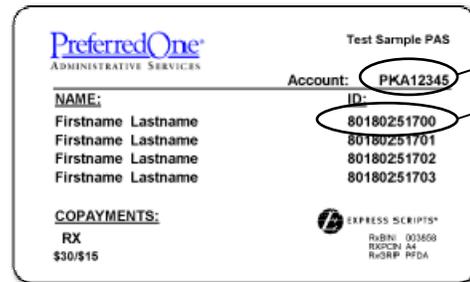
Account Number \_\_\_\_\_

I authorize the above fitness center 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.**



**e.service® Fitness Rewards®**

- \_\_\_ A. I understand each adult must work out a minimum number of days per calendar month, as required by the employer, 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.