HEALTHPARTNERS
FREQUENT FITNESS PROGRAM PARTICIPATION FORM

Participant Information

Name of person #1 participating: _____

HealthPartners Member ID # _____ HealthPartners Group # 34604

Gender: M F Birth Date____ /____ /____

Wartburg ID #: _____

Name of person #2 participating: _____

HealthPartners Member ID #_____ HealthPartners Group # 34604

Gender: M F Birth Date____ /____ /____

Wartburg W Member #: _____

Address Information

Street Address: _____

City: _____ State: _____ ZIP:_____

Primary Phone: _____

Email Address: _____

Type of W Membership: Employee Only ❑ Employee +1❑ Family❑

A. I understand each adult must work out a minimum number of days per calendar month to receive a reimbursement toward the facility's membership dues. The maximum monthly monetary incentive amount and workout requirement is determined by HealthPartners and may be changed with notification through standard member communications in cooperation with the facility. Each adult can qualify for a monthly reimbursement toward membership dues. A maximum of two qualifying adults per household may participate in the program.

B. I understand that an adult may be partially or wholly ineligible for Frequent Fitness reimbursement in a given month if monthly club dues are less than the stated monetary incentive. Examples of this may be obtained from the facility if applicable.

C. I understand there will be approximately a two-month lag between the time I complete my workouts and the month I receive the reimbursement. For example, workouts completed in September are verified in October, with reimbursement applied to the facility's account in November in most cases.

D. I understand the canceling my membership at the facility or dropping my HealthPartners coverage, or becoming otherwise ineligible for the Frequent Fitness program will result in forfeiture of any unapplied reimbursements.

E. I understand that it is each participating adult's responsibility to ensure that each of his or her visits is recorded at the facility.

F. I understand that only one (1) workout per day will count toward the monthly total for the Frequent Fitness program.

Reimbursement is subject to program terms and conditions. HealthPartners reserves the right to modify reimbursement levels or terminate the program and may do so at any time.

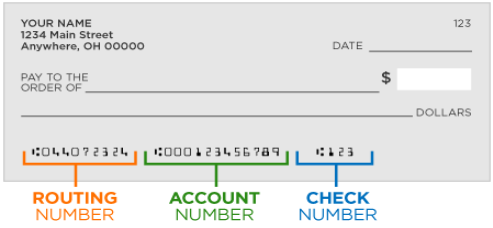
Banking Information for Direct Deposit:

Banking Institution Name: _____

Routing #: _____

Account #: _____

Account Type: Checking ❑ Savings ❑



Employee Signature: _____ Date: _____

Please return completed form to Sheila Kittleson at The W