

Phone # (573) 632-5634 / 632-5614

Scan Card Renewal
I.D. Number: _____ New

M
 F DOB _____ Age _____

Member's Name _____
(Last) (First) (Middle)

Address _____
(Number) (Street) (City) (Zip Code)

Home Phone _____ Work Phone _____

Cell Phone _____ Email: _____

Emergency Contact / Relationship _____ Phone _____

How did you hear about the program: _____

Goals: Flexibility Performance enhancement Weight loss Strength Stamina
 Cardiovascular Post Rehabilitation General Fitness

PAYMENT OPTIONS AVAILABLE (check below): **All payments are non-refundable.**

Join Fee: \$45/ indiv. <input type="checkbox"/>	Cash / Check / Credit Card	EFT-monthly (will need EFT form)	CRMC Payroll-sign box below	
Join Fee: \$65 / couple <input type="checkbox"/>	INDIVIDUAL		FAMILY	
Join Fee: \$85 / 3+ <input type="checkbox"/>	Monthly	6 Months	Monthly	6 Months
Regular:	\$35	\$177	\$61	\$307
Senior (62+):	\$27	\$137	\$45	\$227
CRMC Employee:	\$17	NA	\$37	NA
Corporate:	\$32	\$162	\$56	\$282
Company Sponsored Employee / Family:	Company Name:	Employee:	Price from contract:	
Other :				
Full Charge (1-9)	½ month charge (10-19)	Start next month (20-31)		

PLEASE READ AND SIGN

1. Monthly rates require an electronic fund transfer form with a voided check.
2. Healthplex membership fees are subject to change. Refer to Membership Practices and Facility Guidelines under payment plans.
3. CRMC employees using payroll deduction must sign in the payroll box provided.
4. 6-month members will be sent a renewal reminder one month before expiration. If your membership is not renewed, membership will go to terminated status.
5. A 30-day written notice is needed to cancel/terminate your membership.
6. Terminated/cancelled members will need to pay new joining fee when reactivating membership.
7. A \$25 fee will be assessed for all returned checks.
8. Freezes require a special form completed and fee of \$5.00 for individual and \$10 for family per month.
9. Refunds cannot be given on partially used membership plans.
10. I have received a copy of the Membership Practices and Facility Guidelines and agree to the terms and conditions.

Signature (all members)

Date HP Staff

CRMC EMPLOYEES ONLY (PAYROLL DEDUCT)

I hereby authorize the Payroll Department of Capital Region Medical Center to make payroll deductions from my paycheck for my Healthplex membership dues. I agree for the dues to be deducted until I personally sign a cancellation form.

Signature (CRMC employees)

Date

Sent to Payroll:

Date _____ Initials _____