

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

Scan Card Renewal
I.D. Number: _____ New

Member's Name _____ M F
(Last) (First) (Middle) DOB _____ Age _____

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"/>	<input type="checkbox"/> Paid Full	<input type="checkbox"/> EFT (monthly)	<input type="checkbox"/> CRMC Payroll			
Join Fee: \$65 / couple <input type="checkbox"/>	INDIVIDUAL		FAMILY			
Join Fee: \$85 / 3+ <input type="checkbox"/>	Monthly	6 Months	Year	Monthly	6 Months	Year
Regular:	\$33	\$165	\$297	\$59	\$295	\$531
Corporate/Student:	\$30	\$150	\$270	\$54	\$270	\$486
Senior (62+):	\$25	\$125	\$225	\$43	\$215	\$387
CRMC Employee:	\$15	NA	NA	\$35	NA	NA
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. CRMC employees must sign in the payroll box provided.
3. 6-month or year members will automatically renew unless notification of cancellation.
4. A 30-day written notice is needed to cancel your membership.
5. A \$25 fee will be assessed for all returned checks.
6. Freeze fee of \$5 per person per month for extended vacation or medical holds available when completing appropriate form in advance only.

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 _____