

# Blueprint for Health® fitness discounts Enrollment Form



**BlueCross BlueShield of Minnesota**

An Independent Licensee of the Blue Cross and Blue Shield Association

ES \_\_\_\_\_ Fitness Center Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_

**Type of Authorization:**     New Authorization     Change in Account Information     Change in Insurance Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 BlueCross Member I.D.# \_\_\_\_\_ BlueCross Subscriber ID # \_\_\_\_\_  
 BlueCrossGroup # \_\_\_\_\_ - \_\_\_\_\_ 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 and Vanco Services, LLC 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.**

The top card is from BlueCross BlueShield of Minnesota. It shows fields for RxBIN (610455), GRP (T0304-7A), ISSUER (NOT ASSIGNED), ID (XZA 999999999), NAME (ELIZABETH M SAMPLNAME), CARE TYPE (TRIPLE GOLD), SVC TYPE (Rx Covrg, Office Copay), NATIONAL (NONE), and PCP (PROVIDER NAME PRINTS HERE XXXX). Arrows point from these fields to labels: Group ID (GRP), Subscriber ID (ID), and Member ID (CARE TYPE).

The bottom card is from CCS tpa. It shows fields for ID (XZ99999901), NAME (JOHN W LAST NAME), GROUP NUMBER (5MN09990), GROUP NAME (MEDICAL & PRESCRIPTION PLAN), RX BIN (610455), RX PCN (PGIGN), and RX Network (Prime Therapeutics, Inc.). Arrows point from these fields to labels: Subscriber ID (ID), Group ID (GROUP NUMBER), and Member ID (ID).

**PLEASE ATTACH VOIDED CHECK HERE.**



**e.service® Fitness Rewards®**

Please initial the following:

- \_\_\_ A. I understand each adult must work out twelve (12)\* days per calendar month 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.

\* Some employers' plans may be at eight visits per month, check with your employer for details.