Member Enrollment Form 1 of 2



Member & Program Information

All programs require that each member show proof of eligibility and completes their own form to enroll, even when sharing a joint policy or membership. *Additional forms may be required by health plan and may be requested at any time for completion. Failure to complete form or inaccurate information could be cause for rejection or suspension of benefits.

Member Information (Each memb	er must complete their ow	ın form).
Member's First Name: Member's		ast Name:
Address:		
City:	State:	Zip Code:
Gender: M / F DOB:		
Program Information		
Benefit Provider's Name:		
Identification Number:		
Group Number (if applicable):	Sub ID	(if applicable):
outlined by my program provide B. I understand that each enrolled and that it is my responsibility visit requirement is determined that organization. C. I understand that there will be and the month I receive the rei. D. I understand that the reimburse credit is applied.	er. I adult must visit this facility a co to ensure these visits are recorded by my health plan/employer grown approximately a two-month lago mbursement. ements issued cannot exceed the	ertain number of days each calendar month, ed at the facility. This monetary incentive and oup and may be changed with notification from time between the time I complete the visits total monthly membership for the month the
N	Make a copy of the insur activation letter or othe eligibility here.	rance card, r proof of

Club Personnel: Please keep these records in a safe secure location. Do not fax, email, or mail them to Healthy Contributions. All information should be destroyed upon termination of membership.

Member Enrollment Form 2 of 2



Deposit Information

Member: Please fill out this section and provide a copy of a voided check to ensure that data entry of numbers will be accurate. For your own protection, do not use a deposit/withdrawal slip as this often displays different information than the actual account.

Direct Deposit Information of Member - Please check one option below:

Electronic Funds Transfer:	Savings		
Name on Account:			
Financial Institution:			
YOU MAY PASTE A VOIDED CHECK BELOW (OVER THE EXAMPLE CHECK PROVIDED		
JOHN A. DOE	0123		
JANE A. DOE 123 Main Street	DATE		
Anywhere, USA 12345	DATE		
PAY TO THE ORDER OF	\$		
XQUR BANK, USA	DOLLARS		
ARRONAL SALVE			
МЕМО			
(1012345678C) 01234567890123F 0123			
	•		
Routing Number: (Must be 9 digits, cannot begin with a "5")	Account Number:		
agree to not hold Healthy Contributions responsible for any dela supplied by me or by my financial institution or due to an error account. If funds are deposited in error, I understand that a ret	on the part of my financial institution in depositing funds into my		
Signature:	Date:		
Club Personnel: Please keep these records in a safe secure le	ocation. Do not fax, email, or mail them to Healthy Contributions.		

Healthy Contributions | 12181 Margo Avenue South | Hastings, MN 55033 | P: 800.317.2739 | F: 651.438.5196

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