

**HEALTHPARTNERS FREQUENT FITNESS PROGRAM AGREEMENT**

**1<sup>st</sup> Insured:**

Member name: \_\_\_\_\_ Member number: \_\_\_\_\_  
HealthPartners Member ID # \_\_\_\_\_ HealthPartners Group # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Email Address \_\_\_\_\_

**2<sup>nd</sup> Insured**

Member name: \_\_\_\_\_ Member number: \_\_\_\_\_  
HealthPartners Member ID # \_\_\_\_\_ HealthPartners Group # \_\_\_\_\_

- A. I understand each adult must work out 12 times per calendar month to receive the \$20 reimbursement toward the CLUB membership fee. Each adult can qualify for a \$20 monthly reimbursement toward the membership fee. A maximum of two qualifying adults per household may participate in the program.
- B. I understand there will be approximately a two-month lag between the time I complete my workouts and the month I receive the reimbursement. Example: work out in September, verified in October, reimbursement applied in November.
- C. I understand the canceling my CLUB membership or dropping my HealthPartners coverage, or becoming otherwise ineligible for the Frequent Fitness program, will result in forfeiture of any unapplied reimbursements.
- D. I understand that it is each participating adult's responsibility to ensure that their visit is recorded at the CLUB.
- E. I understand that only 1 workout per day will count toward the monthly total for the Frequent Fitness program.

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date