CAPITAL REGION MEDICAL CENTER
University of Missouri Health Care

HEALTHPLEX MEMBERSHIP APPLICATION

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

Scan Card **Renewal** ❑
I.D. Number:_____ **New** ❑

Member's Name_____ ❑ M ❑ F DOB_____ Age____
(Last) (First) (Middle)

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

Home Phone_____ Work Phone_____ Cell _____

Person to contact for emergency _____

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.**

❑ **Paid in Full** ❑ **EFT (complete EFT Form)**

❑ Joining Fee $40	INDIVIDUAL				FAMILY			
	EFT	Monthly	6-Month	1 Year	EFT	Monthly	6-Month	1 year
Regular Fitness	❑ $33	❑ $43	❑ $160	❑ $290	❑ $59	❑ $69	❑ $285	❑ $530
Corporate Fitness-Employer:	❑ $30	❑ $40	❑ $144	❑ $270	❑ $54	❑ $64	❑ $258	❑ $495
Senior (62+ years)	❑ $25	❑ $35	❑ $118	❑ $220	❑ $43	❑ $53	❑ $207	❑ $385
CRMC Employee ❑ payroll deduct ❑ bill member	❑ $20	❑ $30	❑ $92	❑ $174	❑ $43	❑ $53	❑ $207	❑ $385

❑ Company Sponsored (employee)
❑ Company Sponsored (family member of employee)
Employer:
Employee Name:

❑ Other ❑ Assisted

❑ Full Charge this month (1-9) ❑ ½ month charge (10-19) ❑ Start charging next month (20-31)

ALL MEMBERS

- **Membership plans are NOT based on the number of times attended or if attended.**
- **Members paying for 6 months or one year will receive a renewal reminder upon expiration (payments non-refundable).**
- **EFT members have completed and read Automatic Draft Form.**
- **Monthly statement members will be continually billed at the beginning of the month and payment due by the 10th of the month ($10 monthly processing fee will be added).**
- **A 15 day written notice is needed to terminate membership.**
- **A $25 fee for all returned checks.**

_____
Signature (all members)

_____ _____
Date HP Staff

CRMC EMPLOYEE ONLY

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 only)

_____
Date

Sent to Payroll:

Date_____ Initials_____