THE COMMUNITY HOSPITAL
Fitness Pointe®
9950 CALUMET AVENUE, MUNSTER, IN 46321
PHONE: (219) 924-5FIT
FAX: (219) 924-8581

MEMBERSHIP APPLICATION

Member # _____

NAME LAST FIRST M.I. AGE BIRTHDATE GENDER

HOME ADDRESS STREET CITY STATE ZIP PHONE (HOME)

NAME OF EMPLOYER (IF APPLICABLE) PHONE (WORK)

E-MAIL

PLEASE CHECK CLASSIFICATION OF MEMBERSHIP DESIRED:
☐ Individual ☐ Senior Individual ☐ Corporate_____ ☐ Community Healthcare System – specify: Employee, Medical Staff, Board, Volunteer, Retiree

☐ First Additional Household Member* Name_____ DOB _____ MEMB # _____

☐ 2nd Additional Household Member** Name_____ DOB _____ MEMB # _____

Name _____ DOB _____ MEMB # _____

*Applies to any individual (16 years or older) residing at the same address. Proof of residency required.
** Applies to a child (16-24 years of age) of either the individual member or the first additional household member.

MEMBERSHIP PAYMENT

MONTHLY PAYMENT PLAN AUTHORIZATION

A. I desire convenience, control and privacy for payment of my dues. I request that my monthly dues be charged directly to my bank/corporation as per my (check one): ☐ Checking Account, ☐ Credit Card. The monthly dues charge will be made the 10th day of the month or each pay period. I understand that I do not have to write a check for my dues and that there is no extra charge for this service. This monthly payment plan allows me to terminate my membership upon 30 days written notice.

1. Checking Account Option
   NOTE: Application for checking account monthly dues payment cannot be processed unless a voided check, which shows your account number, is attached.

2. Credit Card Option
   Payment Options: ☐ Master Card ☐ VISA ☐ Discover Account No. _____ Exp. Date _____

3. Community Hospital Payroll Deduction Employee No. _____

Upon acceptance of the application by Fitness Pointe®, the undersigned shall receive the membership privileges and agrees to abide by all guidelines and policies of Fitness Pointe®, which are subject to change and which, in the opinion of facility management, are deemed necessary and reasonable for the best interests of its members and Fitness Pointe®. I understand that the enrollment fee is a one-time-only charge, as long as my membership is in good standing, and must be paid at the time I submit this membership application. I agree that Fitness Pointe® may charge my method of payment indicated above for any partial month's charges that will be prorated for this 30 day period. Fitness Pointe® reserves the right to change the monthly dues at any time by giving 30 days written notice.

If I cancel my membership or it is terminated by Fitness Pointe, other than for an approved leave of absence, and I wish to rejoin, I will be subject to a re-enrollment fee at that time. The initial payment of membership fees and monthly dues are not refundable unless membership is canceled within 30 days after signing the application.

CANCELLATION POLICY: The Community Hospital Fitness Pointe® requires 30 days written notice from the member to cancel. The approved cancellation will take effect on the first day following this 30 day period. The Community Hospital reserves the right to terminate a membership with 30 days written notice to the member.

Applicant Signature _____ Date _____ Joining Fee $_____

Legal Guardian _____ Date _____ Monthly Dues $_____

Approved and Accepted by _____ Date _____

Rev. 12/17/2013 WHITE – Fitness Pointe® YELLOW – Member