Powers HEALTH℠

Community Hospital Fitness Pointe®
9950 Calumet Ave., Munster, IN 46321
P: 219-924-5348 | F: 219-924-8581

Membership Application

Account # _____

Name: _____ **Age:** ____ **Birthdate:** _____ **Gender:** _____
Last First Middle Initial

Address: _____
Street City State Zip

Phone: _____ **Email:** _____

Name of Employer (if applicable): _____

Membership Payment

Monthly Payment Plan Authorization

I desire convenience, control and privacy for payment of my dues. I request that my monthly dues be charged directly to my bank/corporation/payroll as per my (check one). 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 of a written notice.

❑ **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.

❑ **Credit Card Option**
Payment Options: ❑ Mastercard ❑ Visa ❑ Discover ❑ American Express
Card Number _____
Expiration Date _____

❑ **Powers Health Payroll Deduction**
Payroll Code (Circle one): CH CVI PH PHM PHR SCH SMM
Employee Number _____

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 a 30-day 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: Community Hospital Fitness Pointe requires 30 day's written notice from the member to cancel. The approved cancellation will take effect on the first day following this 30-day period. Fitness Pointe reserves the right to terminate a membership by giving a 30-day written notice to the member.

Applicant Signature _____ Date _____ Joining Fee $ _____

Legal Guardian _____ Date _____ Monthly Dues $ _____

Approved and Accepted by _____ Date _____