HEALTHY CONTRIBUTIONS REIMBURSEMENT ENROLLMENT FORM

Primary Applicant's Name _____

Member #_____

Activation ID #_____

Gender: M F Birth Date_____

Secondary Applicant's Name _____

Member #_____

Activation ID #_____

Gender: M F Birth Date_____

Address _____

City_____State_____ ZIP_____

Home Phone _____Work Phone _____

Email Address _____

A. I understand each enrolled adult must visit the participating fitness center a minimum number of twelve (12) days per calendar month to receive a reimbursement in my checking or savings account. The maximum monthly monetary incentive amount and Club visit requirement is determined by UnitedHealthcare and may be changed with notification through standard member communications in cooperation with Healthy Contributions, LLC and the fitness center. Only eligible members and spouses notified by UnitedHealthcare can qualify for a monthly reimbursement toward membership dues. 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 Club visits and the month I receive the reimbursement. For example, Club visits completed in September are verified in October, with reimbursement applied in November in most cases.

C. I understand that it is each participating adult's responsibility to ensure that each of his or her Club visits is recorded at the fitness center.

D. I understand that only one (1) Club visit per calendar day will count toward the monthly total for the program.

Signature_____ Date _____ Club Associate Initials _____

Reimbursement is subject to program terms and conditions. UnitedHealthcare reserves the right to modify reimbursement levels or terminate the program and may do so at any time.

DEPOSIT INFORMATION

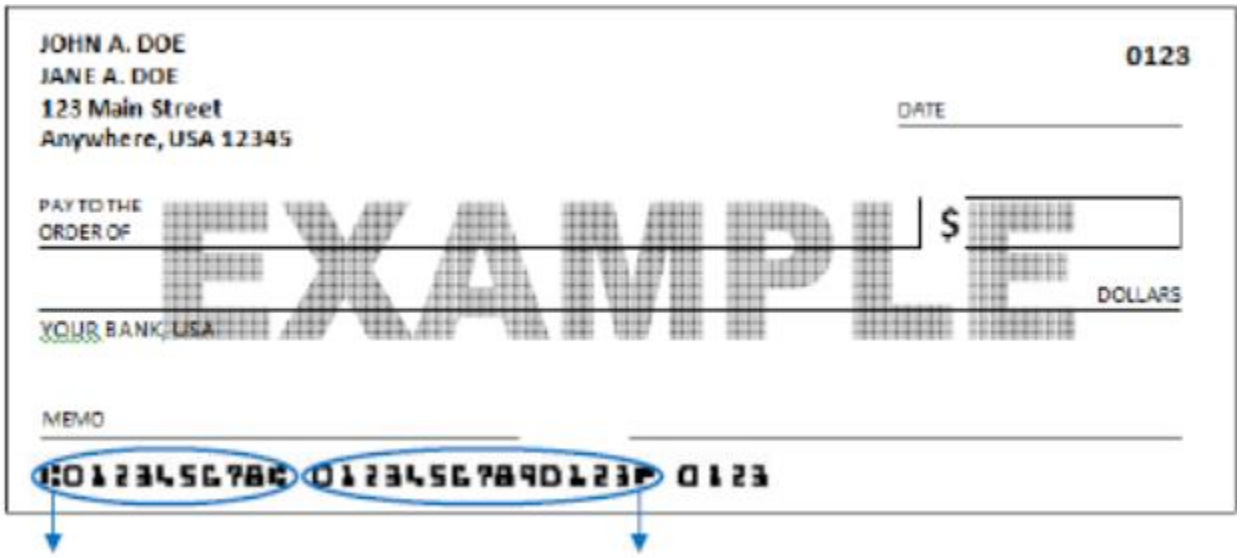
Member: Please fill out this section and provide a copy of a voided check to ensure that data entry of numbers will be accurate. For your own protection, do not use a deposit/withdrawal slip as this often displays different information than the actual account.

Name on Account _____

Financial Institution _____

Electronic Funds Transfer: Checking Savings

You may paste a voided check below, over the example check provided, or fill in the Routing and Account Number in the area provided.



Routing Number:_____ Account Number: _____

(Routing number must be 9 digits, cannot begin with a "5")

I authorize Healthy Contributions to initiate automatic deposits to my account at the financial institution indicated above. Further, I agree to not hold Healthy Contributions responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds into my account. If funds are deposited in error, I understand that a retraction may occur. This agreement will remain in effect until Healthy Contributions receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to Healthy Contributions.

Signature_____ Date _____