



Ucani Ucare Activity Network

Participation Form

Ucare I.D.# 000 _____ (11 digits total)

Policyholder's First Name _____ Last _____ MI _____

Date of Birth _____ / _____ / _____

Address 1 (City) _____ State _____ Zip _____

Address 2 (City) _____ State _____ Zip _____

Daytime Phone _____

Second participating adult (must be insured through policyholder listed above):

Ucare I.D.# 000 _____ (11 digits total)

First Name _____ Last _____ MI _____

Date of Birth _____ / _____ / _____ Daytime Phone _____

Ucare members: Indicate that you understand and agree to the following statements by initialing each line below:

- _____ A. I understand that each *UCare for Seniors* member must visit a participating health club and work out eight (8) times per calendar month to receive the \$20 reduction in monthly club/fitness center membership fees. Limit: One \$20 monthly dues reduction per member meeting attendance criteria.
- _____ B. I understand the reduction issued cannot exceed the total monthly membership for the month in which the reduction is applied.
- _____ C. I understand there will be an approximately two-month period between the completed month of attendance and the applied dues reduction. Example: work out eight times in February; this is verified and processed in March, and the reduced monthly fee is applied in April.
- _____ D. I understand that canceling my health club membership will result in forfeiture of any unapplied dues reductions.
- _____ E. I understand that it is each member's responsibility to ensure that his or her visit is recorded by the club at the time of the club visit.

Signature _____

Fitness Center use only:

Date _____ / _____ / _____	Club member since date _____ / _____ / _____
_____	Club # _____
_____	Average monthly dues _____
_____	Average monthly dues _____
_____	Fitness Center Member 1 # _____
_____	Fitness Center Member 2 # _____

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