

EZFit Enrollment Form

Please attach:

- **Voided check, or bank routing information**
- **Proof of payment for gym membership dues**

Member Name: _____ Subscriber ID: _____
(Separate form required for each participant)

Health Club Name: _____ Phone: _____

Health Club Address: _____

Cost of Dues: \$ _____ per month

Claim is for (Check one):

Subscriber (policy holder) Spouse (of policyholder) Dependent (18 to 26)

I authorize the release of any health club membership information HealthEZ may need to process this fitness reimbursement request. I certify that the information provided is complete and correct.

Signature: _____ Date: _____

Please send to HealthEZ:

Email: EZFit@healthEZ.com

Mail: HealthEZ

Attn: EZFit
7201 W. 78th St.
Suite 100
Bloomington, MN 55439