# Membership Bridge/ Medical Freeze Request

## General Information

Member(s) Name* Date

Member ID Membership Type

Address City State Zip

Email Address* Phone*

*Required fields

## Request Details

(Choose Bridge or Medical Freeze and mark as applicable; refer to the **Membership Bridge/Medical Freeze Policy** document for guidelines.)

Requested Start Date _____ /_____ /_____ Requested End Date _____ /_____ /_____

☐ **Bridge:** ☐ Member Listed Above Only ☐ Entire Membership

☐ **Medical Freeze:** ☐ Member Listed Above Only ☐ Entire Membership

☐ **Relocation Bridge:** ☐ Member Listed Above Only ☐ Entire Membership

Address City State Zip

By signing below you acknowledge that you have read and agree to the terms and conditions within the Membership Bridge/Medical Freeze Policy.

_____ **(Member Initials)** I understand that at the conclusion of my bridge/freeze period, my membership will become active and membership charges/billing will automatically resume. I also understand that if I have an active Remote Health and Fitness Coaching program enrollment contract, and my center membership is **approved for a bridge**, my Remote Health and Fitness Coaching program will remain active and will continue to bill on a monthly basis until my Remote Health and Fitness Coaching program is canceled as set forth within my Remote Health and Fitness Coaching program contract; my Remote Health and Fitness Coaching program will continue to be available to me throughout the duration of my bridge. If I have an active Remote Health and Fitness Coaching program enrollment contract, and my center membership is **approved for a medical freeze**, my Remote Health and Fitness Coaching program will be canceled as set forth within my Remote Health and Fitness Coaching program enrollment contract. I also understand that during my bridge/freeze I shall not have access to the center except for community events open to members and non-members.

Member Signature Date

Employee Signature Date

**Send to kkahler@powerwellness.com**

## For Office Use Only

☐ Approved ☐ Not Approved # Months Approved _____ # Additional Days Approved _____ (Medical Freeze Only)

Billing Adjustments Begin Billing Adjustments End

Total Monthly Dues

Yearly Expiration Extension: From _____ /_____ /_____ To _____ /_____ /_____

Comments

Accounting Staff Signature Date