



## **New Plan Setup Form**

Primary Facility Name PARKS PLUS FITNESS CENTER

Full Legal Entity Name (ex: Gym, LLC/Gym, INC) PARKS PLUS FITNESS CENTER

Primary Contact Name Michelle Artis Primary Contact Number 630.510.5135

Primary E-Mail address (If different than Signee) martis@wheatonparks.org

Facility Website URL WWW.PARKSPLUSFITNESS.COM

County your facility is located in DUPAGE

Are complimentary group fitness classes available at your facility? ☒ Y / N

Does your facility have a pool? ☒ Y / N

Is your facility: ☒ Co-Ed ☐ Women Only

### **SELECTION OF PLAN: AARP Medicare Supplement Program**

This program is charged at \$5.00 per month once there is 1 or more eligible AARP Medicare Supplement Program members enrolled. There is a one-time \$1.50 charge for each new member entered into the Healthy Contributions portal. There is also a \$0.25 monthly charge per location to deposit the AARP Medicare Supplement funds directly to the club. Finally, there is a maintenance fee of \$0.15 per member/per month.

By participating in the Program, you agree to be bound and comply with all Program guidelines and rules and regulations as they may be adopted from time to time, including without limitation, those set forth in the AARP Medicare Supplement Program Information Guide. Please review this packet carefully. You have seven (7) days from the date hereof to choose to opt-out of participation in the Program by emailing [network@healthycontributions.com](mailto:network@healthycontributions.com) with a definite statement requesting to opt-out of the Program. If you do not opt-out of the Program within this timeframe, you will be deemed to have accepted the terms and agree to participate in the AARP Medicare Supplement Program, in compliance with the AARP Medicare Supplement Program Information Guide and with all Program guidelines and rules and regulations adopted from time to time.

By signing this document, I agree that I have read and understand the terms and conditions as outlined within the AARP Medicare Supplement Program Information Guide and the original Healthy Contributions Active agreement signed by my location (available upon request).

Signee Name (Print) \_\_\_\_\_

Signee Signature [Signature] Today's Date 12/10/10

Signee E-mail address \_\_\_\_\_

Please scan and email back to [network@healthycontributions.com](mailto:network@healthycontributions.com) or fax back to (651) 438-5196.