

BWI - Orlean Niagara BOCES

Program provided by BWI Health Promotions



Winter/Spring 2010

PARTICIPANT REGISTRATION FORM

Please Complete Entire Form to be Eligible for Insurance-Based Programs, thanks.

- | | | |
|---|--|---|
| <input type="checkbox"/> Community Blue of WNY ♦ | <input type="checkbox"/> Independent Health* | <input type="checkbox"/> Univera ⊖ _____ (list specific program) |
| <input type="checkbox"/> Traditional Blue of WNY ♦ | Independent Health's | <input type="checkbox"/> Univera Community Health ⊖ |
| <input type="checkbox"/> BlueCross BlueShield of WNY ♦ | FlexFit Debit Card Programs... | <input type="checkbox"/> Other _____ (not eligible for discounts) |
| <input type="checkbox"/> Senior Blue of WNY ♦ | <input type="checkbox"/> FlexFit Family + | <input type="checkbox"/> Insurance Info On File at BWI: Last class _____ |
| <input type="checkbox"/> BlueCross BlueShield Child Health Plus ♦ | <input type="checkbox"/> FlexFit Independent Δ | <input type="checkbox"/> Cash/Check Paying Customer |
| <input type="checkbox"/> BlueCross BlueShield Healthy New York ♦ | <input type="checkbox"/> FlexFit Personal Best ^ | <input type="checkbox"/> Credit Card/Debit Card Paying Customer: MC Visa |

PARTICIPANT'S NAME

First MI Last

INSURANCE ID#

3-Letter Prefix (YJC/YJP) 9 Digit ID# (sample: 880123456) 2 Digit Suffix (01) GROUP #

CREDIT CARD or IH FLEX FIT DEBIT CARD

(16-digit card#) (3-Digit Code) (Expir. Date)

BIRTH DATE*

* Must have to bill.

BILLING ZIP*

IF POLICY IS NOT IN YOUR NAME

Card Holder's Name or Same Relation to Card Holder Card Holder's Employer

NAME

DATE

STREET

CITY

ZIP

TELEPHONE: HOME

WORK

EXT

E-MAIL ADDRESS

Please tell us how you heard about our BWI Promotions:

PROGRAM INFORMATION:

Check <input checked="" type="checkbox"/>	Program	Day(s)	Time(s)	Start Date	Length	Instructor	Cost	25% Off	FREE	25%
	Yogalates	Wed.	4:15-5:30pm	1/13/2010	8-wks	Linda O.	\$100	\$75.00	♦ Δ	⊖ +
	Jump Start Your Fitness	Wed.	4:15-5:30pm	4/7/2010	8-wks	Linda O.	\$100	\$75.00	♦ Δ	⊖ +

All Insurance Participants - I understand that signing-in is required to be eligible for insurance-reimbursement.

Please confirm that the personal history and insurance card information listed above is accurate and complete.

Also, in signing this, I verify that I have not previously taken this class since January of this year.

Fitness Classes Only - I understand that if I do not complete 100% of classes as required by BCBS of WNY that I am not eligible

for FREE insurance reimbursement and am responsible for personal payment via cash/credit card or check. X _____ (your initials)

Community Exercise Orleans Niagara BOCES

FOR STAFF USE ONLY:

Date _____ Amount Paid \$ _____

Check/Cash/CC Receipt # _____

Check # _____

Program: Pymt IB-FREE Staff Initials _____