



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 jhoward@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 _____