NIHCA
National Independent Health Club Association

FOR OFFICE USE ONLY
Facility Name
Facility #
State **City**

Membership Activation Form

Fitness Facility Name

Physical Address

City State Zip Code

Mailing Address

City State Zip Code

Business Phone

Toll Free Phone Fax

Facility's Website

Facility's Email

FOR OFFICE USE ONLY
- ☐ **SalesForce**
- ☐ **Packet**
- ☐ **Quickbooks**
- ☐ **Constant Contact**
- ☐ **Email Partners**
- ☐ **Email BCMN**
- ☐ **Website**
- ☐ **Full Club Report**
- ☐ **Walkthrough**
- ☐ **Paid**
  - ☐ **Check _____**
  - ☐ **CC _____**
  - ☐ **ACH _____**
  - ☐ **$ _____**
- ☐ **_____**

CONTACT INFORMATION

Primary Contact Person Title Phone Email

Secondary Contact Person Title Phone Email

FITNESS FACILITY AMENITIES

☐ Weight Room/Free Weights	☐ Aerobic Studio	☐ Cardio Equipment	Handicap Accessible
☐ Gym	☐ Running/Walking Track	☐ Locker Room	Pool
☐ Tanning	☐ Meeting Room	☐ Scan-in system	24-hour access
☐ Restaurant/Snack Bar	☐ Fitness Classes	☐ Personal Training	_ Child Care

INVESTMENT INFORMATION

Annual Investment

- ☐ National Facility $ 99 (*located outside MN, ND, WY)*
- ☐ MN Facility $ 399 (*located in Minnesota)*
- ☐ ND Facility $ 399 (*located in North Dakota)*
- ☐ WY Facility $ 399 (*located in Wyoming)*

I would like to pay by:

- ☐ Check # _____
- ☐ ACH (Automated Check) – fill out page 2
- ☐ Credit/Debit Card – fill out page 2

RETURN TO:

National Independent Health Club Association
165 8th Ave, Suite #1
Granite Falls, MN 56241
Phone: (320) 722-0084
Toll Free Phone: (866) 484-9173
Fax: (320) 722-0095
Email: info@nihca.org

www.NIHCA.org

Indemnification: By its signature below, the above facility ("Indemnitor") agrees to indemnify and hold the NIHCA and participating Partners ("Indemnitees") harmless with respect to any claims or actions instituted by third parties that result from the use of Indemnitor's services or facilities, including any claims for death, personal injury or property damage, deceptive trade practices, or the use or misuse of information provided by Indemnitees.

Authorized Signature **Date**

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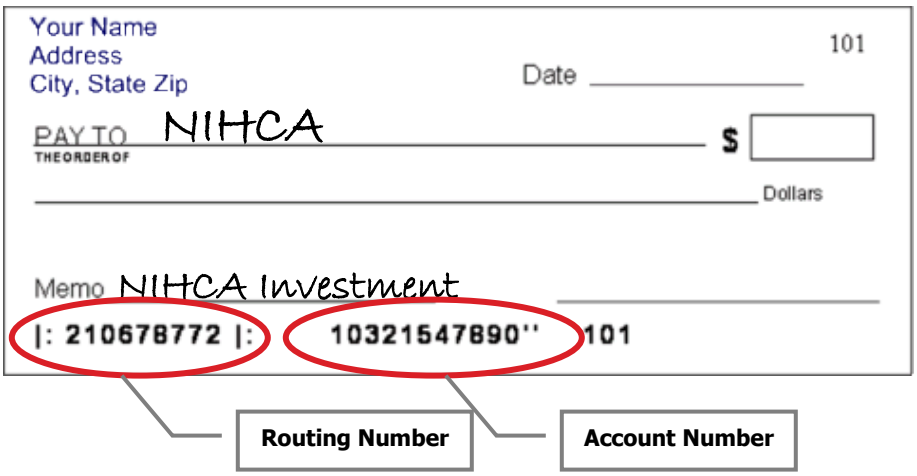
165 8th Avenue | Granite Falls, MN 56241
Toll Free (866) 484-9173 | Fax (320) 722-0095
coord@nihca.org | info@nihca.org

Membership Payment Form

☐ **Payment by ACH (Automate Check)** *Preferred



Payment Amount $ _____

Account Holder's Name _____

Routing Number _____ **Account Number** _____

I hereby authorize this payment to NIHCA, while agreeing to the disclosures below.

_____
Authorized Signature **Date**

☐ **Payment by Credit Card** *Choose One

☐ VISA ☐ MasterCard

Payment Amount $ _____

Card Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration Date ___ ___ / ___ ___ **CVV #** ___ ___ ___ (3 digit # on back of card)

Name on Card _____ **Zip Code** _____

I hereby authorize this payment to NIHCA, while agreeing to the disclosures below.

_____
Authorized Signature **Date**

Disclosures:

1. *A service fee of $20 will be charged for any billing errors that are a result of inaccurate billing information provided by the client, or payment being declined due to insufficient funds.*
2. *By choosing to make a monthly payment, you agree to a 12-month consecutive contract payable to NIHCA.*
3. *NIHCA reserves the right to charge late fees after 30 days overdue at the rate of $20 per month.*