The Arc
Lexington
New York

FIT HAPPENS CORPORATE MEMBERSHIP

From: *12/15/2020* To: *12/14/2021*

Employee Name: _____ Employee ID#: _____

Phone Number: _____ Cost Center #: _____

Are you a new member? Y / N (circle one) Length of Membership: 1 Year

Select Package	Package Description (All packages include weight room orientation)	Bi-Weekly Payroll Deduction
_____	One Year Individual Membership for $324 per year	$12.47
_____	One Year Couples Membership for $648 per year	$24.93
_____	Family Membership: One Year for 2 adults and up to 2-dependent children ages 13 through 18 residing in the same household for $756 per year	$29.08
_____	Tanning Add-On: $12/year PER MEMBER # of Members: _____	$0.47 x # of members: $____
_____	Spinning Add-On $60/year PER MEMBER # of Members: _____	$2.31 x # of members: $____
_____	Additional Youth Add-On $24/year PER MEMBER # of Members: _____	$0.93 x # of members: $____

Confirm your Total Bi-weekly payroll deduction: $_____

I give permission to pay for my membership through payroll deduction. Should my employment with Lexington Center end, I agree any outstanding membership fees will be deducted from my last paycheck. Failure to pay for my membership in full will result in cancellation of my membership.

I also am aware there will be NO refunds, full or partial, on my membership.

_____ _____

Employee Signature Date

Return this form via scan & email to mickelc@thearclexington.org; fax: (518) 725-7939, or interoffice mail no later than 4:00 pm on December 15, 2020 for processing.

Please DO NOT drop off in-person!

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Fit Happens Voluntary Benefit Repayment Agreement

I, _____, have enrolled in
(print your name)

a voluntary benefit through payroll deduction at Lexington Center. Should my employment end, I agree to permit Lexington to withhold any outstanding premium payments from my last paycheck. Lexington agrees to advise me, in writing, of the amount to be withheld.

If the final paycheck is insufficient to satisfy the obligation, I agree to repay Lexington the outstanding balance within 30 days of my last day worked or my gym membership will be cancelled.

Please remit payment to:

Lexington Center
127 E. State Street
Gloversville, NY 12078
Attn: Human Resources

_____ _____

Employee Signature **Date**

_____

Empl ID #

Lexington's mission is to provide the best possible services to children and adults who are disabled and their families, to be the best possible employer for its employees, and to contribute to the good of the community.

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FIT HAPPENS
FACILITY REQUIRED MEMBER INFORMATION

Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Date of Birth: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Family member names included on your membership:

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB_____