

BWI-Eden Community Ed Programs

(Winter/Spring '10)

Programs provided by BWI Family Wellness with Eden Community Education.

Use this form to receive insurance discounts and/or Free programming with BWI.



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

PARTICIPANT'S NAME _____
 First _____ MI _____ Last _____

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

CREDIT CARD or FLEX FIT DEBIT CARD _____
 (16-digit card#) _____ (3-Digit Code) _____ (Expiration 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:

#	Program	Location	Day(s)	Time(s)	Start Date	Length	Instructor	Cost	25% Off	FREE	25%
	Breathe Easy: Living with Asthma	EJSH-Rm 219	Mon.	7-8pm	2/22/2010	1-hr.	BWI Staff	\$15	n/a	♦ Θ	
	Weight Management Program	EJSH-Rm 146	Wed.	3:15-4:15pm	2/24/2010	10-wks/10-days	BWI Staff	\$150	n/a	♦ Θ	
	Living with Arthritis	EJSH-Rm 219	Mon.	7-8:30pm	3/22/2010	1.5-hr.	BWI Staff	\$18.75	n/a	♦ Θ	
	Injury Prevention	EJSH-Rm 219	Mon.	7-8:30pm	4/26/2010	1.5-hr.	BWI Staff	\$18.75	n/a	♦ Θ	
	Be Fit Kids (Grade K-2)	GLP Cafeteria	T/TH	3:15-4:30pm	3/2/2010	10-wks/20-days	BWI Staff	\$200	\$150.00	♦ Θ +	*
	Core Strengthening Session-1	GLP Cafeteria	T/TH	6:30-7:30pm	1/5/2010	4-wks/8-days	Kelly	\$45	n/a		
	Core Strengthening Session-2	GLP Cafeteria	T/TH	6:30-7:30pm	2/2/2010	4-wks/8-days	Kelly	\$45	n/a		
	Core Strengthening Session-3	GLP Cafeteria	T/TH	6:30-7:30pm	3/9/2010	4-wks/8-days	Kelly	\$45	n/a		
	Core Strengthening Session-4	GLP Cafeteria	T/TH	6:30-7:30pm	4/6/2010	4-wks/8-days	Kelly	\$45	n/a		
	Core Strengthening Session-5	GLP Cafeteria	T/TH	6:30-7:30pm	5/11/2010	4-wks/8-days	Kelly	\$45	n/a		
	Yogalates Session-1	GLP Cafeteria	Wed.	7-8pm	1/13/2010	10-wks/10-days	Shawna	\$100	\$75.00	♦ Δ	* Θ
	Yogalates Session-2	GLP Cafeteria	Wed.	7-8pm	3/31/2010	10-wks/10-days	Shawna	\$100	\$75.00	♦ Δ	* Θ
	Yogalates w/ball Session-1	GLP Cafeteria	Sat.	8:30-9:30am	1/9/2010	10-wks/10-days	Shawna	\$100	\$75.00	♦ Δ	* Θ
	Yogalates w/ball for SENIORS-1	GLP Cafeteria	Sat.	8:30-9:30am	1/9/2010	10-wks/10-days	Shawna	\$100	\$75.00	♦ Δ	* Θ
	Yogalates w/ball-Session 2	GLP Cafeteria	Sat.	8:30-9:30am	3/27/2010	10-wks/10-days	Shawna	\$100	\$75.00	♦ Δ	* Θ
	Yogalates w/ball for SENIORS-2	GLP Cafeteria	Sat.	8:30-9:30am	3/27/2010	10-wks/10-days	Shawna	\$100	\$75.00	♦ Δ	* Θ
<i>Eligible BlueCross BlueShield of WNY members may take any 2 exercise sessions per calendar year.</i>									<i>No level 2 pricing available in 2010</i>		

Please read and initial at location indicated:

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 also understand that if I do not complete 100% or better of classes that I am not eligible for insurance reimbursement and am responsible for personal payment via cash/credit card or check.
 X _____ (your initials)

(All information collected on this form will be kept confidential and will be used solely for the purpose of insurance reimbursement)

Eden Community Ed; 3150 Schoolview Rd., Eden, NY 14057
 Questions: Call 992-3629



FOR STAFF USE ONLY:

Date _____ Amount Paid \$ _____
 Check/Cash/CC Receipt # _____
 Check # _____
 Program: Pymt IB-FREE Staff Initials _____