HEALTH FIT
POWERED BY SARASOTA MEMORIAL

Membership Type: _____

Employee Membership Payroll Deduction Authorization Form

First Name: _____ Last Name: _____ Employee ID #: _____

1. Terms of Sarasota Memorial Payroll Deduction for HealthFit Membership

A member must sign Payroll Deduction Authorization Form each time a change the amount of their deduction will occur with the exception of requesting a leave of absence, in which case their signature on the Member Information Change Form will be utilized as their deduction authorization.

A member must submit supplemental billing information in the form of a credit card to be kept on file or a voided check for which HealthFit will be able to charge for membership dues in the event a member terminates employment at Sarasota Memorial Hospital. If termination occurs, membership will continue at Month-to-Month Community Membership rates which will be charged monthly to supplemental billing information provided.

A member must pay prorated dues for the first month they join plus full dues for the second month of membership prior to payroll deduction starting to allow for processing of the payroll deduction paperwork.

Payroll deduction may be used for membership dues only. Any ancillary services such as locker rental or babysitting must be billed via a credit card on file or electronic funds transfer (EFT) from member's bank account.

Payroll deduction will occur on the first two paychecks of each month. The amount of deduction will be determined by dividing the cost of the annual membership fee by 24 (two paychecks per month).

In the event of membership cancellation, final payroll deduction will be taken on the first paycheck after the cancellation effective date. For example, if membership cancellation effective date is 9/1/2013, final deduction will occur 10/3/2013.

The primary member on a payroll deduction account must be the Sarasota Memorial Hospital employee.

2. Sarasota Memorial Payroll Deduction Authorization

Membership Rates Subject to Change Without Notice

Payroll Deduction Amount (per paycheck): $ _____._____

First Deduction Date: _____/_____/20_____

3. LOA/Medical Freeze Request Start_____/_____/20_____ End_____/_____/20_____

By signing below, I understand and agree to the above terms of the Sarasota Memorial Payroll Deduction for HealthFit Membership and authorize the deduction of the amount above from my payroll.

Member Signature _____ Today's Date _____/_____/_____

STAFF USE ONLY

Date copy of Deduction Form faxed to Sarasota Memorial Payroll department at 941.917.5405:

Member # _____ Staff Signature _____ Date _____/_____/_____