

Chelsea Wellness Center

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	____ / ____ / ____
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<input type="checkbox"/> Optional Bridge:	<input type="checkbox"/> Member(s) Listed Above Only	<input type="checkbox"/> Entire Membership
<input type="checkbox"/> Medical Freeze:	<input type="checkbox"/> Member(s) Listed Above Only	<input type="checkbox"/> Entire Membership
<input type="checkbox"/> Relocation Bridge:	<input type="checkbox"/> Member(s) Listed Above Only	<input type="checkbox"/> Entire Membership

Address	City	State	Zip
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By signing below you acknowledge that you have read and agree to the terms and conditions within the Membership Bridge/Medical Freeze Policy. Any adjustments to account billing will begin once your bridge/freeze becomes effective or with the first billing cycle after approval based on the timing of your request.

_____ Member Initials – I understand during my bridge/freeze I shall not have access to the Center except for community events open to members and non-members (Exception: Members on a Bridge may purchase a Bridge Day Pass to use the facility). I also understand at the conclusion of my bridge/freeze dues adjustments, membership charges/billing will resume. Refunds or credits will not be provided for dues already collected if cancellation is submitted during an approved bridge.

Member Signature	Date
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Employee Signature	Date
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For Office Use Only

<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	# Months Approved	_____	# Additional Days Approved	_____
(Medical Freeze Only)					

Billing Adjustments Begin	Billing Adjustments End
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Total Monthly Dues

Yearly Expiration Extension:	From	____ / ____ / ____	To	____ / ____ / ____
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Comments

Accounting Staff Signature	Date
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Return completed form to jhoward@powerwellness.com