

# MEMBERSHIP CANCEL/CHANGE FORM



## **CANCELLATION SECTION** (\$25 cancellation fee)

Name: (First/Last) \_\_\_\_\_ Phone: \_\_\_\_\_

Current Package Type: **select one** → \_\_\_ Annual (1yr.) \_\_\_ 3 Month      **select one** → \_\_\_ Single \_\_\_ Family

Payment: \_\_\_ Paid in Full \_\_\_ Voided Check \_\_\_ Debit/CC \_\_\_ Payroll deduction – Company \_\_\_\_\_

### **Health Club Credit - Reimbursement Program:**

Name of Insurance: \_\_\_\_\_

Name(s) of participants enrolled \_\_\_\_\_

*WAIVER: Please cancel my membership. I understand I am responsible for any balance I may have at West River Community Center along with a \$25.00 cancellation fee. As of the effective date, my membership will no longer be active.*

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **OFFICE USE ONLY:**

Cancellation Effective Date: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

Paid \$25 fee: \_\_\_ CASH # \_\_\_ CHECK \_\_\_ CC Receipt # \_\_\_\_\_

## **UPGRADE/DEGRADE SECTION** (\$10 Degrade Fee)

Name: (First/Last) \_\_\_\_\_ Phone: \_\_\_\_\_

Members Added: \_\_\_\_\_ (DOB) \_\_\_\_\_ (DOB) \_\_\_\_\_

Members Dropped: \_\_\_\_\_

Current Package Type: **select one** → \_\_\_ Annual (1yr.) \_\_\_ 3 Month      **select one** → \_\_\_ Single \_\_\_ Family

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **OFFICE USE ONLY:**

Change Effective Date: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

Upgrade/Degrade To: \_\_\_\_\_ New Cost Per Month if EFT: \_\_\_\_\_

Keep Billing Instructions Same: \_\_\_ Yes \_\_\_ No

Paid \$10 fee: \_\_\_ CASH # \_\_\_ CHECK \_\_\_ CC Receipt # \_\_\_\_\_