

Last	First			Member Number			
PLEASE SELECT REASON FOR FREEZE							
Medical	Financial	U Work Requirement	□ Vacation				
Other							
FREEZE DATES							
Starting Date:		Ending Date:					
Membership Agreen	nent extended by mon	ths. Renewal Date:					
PLEASE READ CAREFULLY BEFORE SIGNING							

Freeze Form must be signed and returned to the business office no later than ______ A monthly \$15 "freeze" fee will be charged each month the account is frozen. Account will NOT be charged the regular monthly dues. This form will not be processed without member's signature.

I, the undersigned, hereby request that the above account be frozen for the time period indicated. In making this request, I agree and acknowledge to the following terms and conditions.

A frozen account may be reinstated at any time by the member. If the account is not reinstated early, it will automatically be reinstated on the freeze end date. I understand that usage of the facilities under this membership is not permitted by myself of my family while the account remains frozen. Failure to comply with this will result in automatic reinstatement.

An account may be frozen for a maximum period of three (3) months per calendar year, unless otherwise approved by the business office.

Members deciding to cancel their membership after the freeze period must obtain and complete a "Cancellation Form" from the business office. This form must be returned no later than twenty (20) days before the date in which they wish to cancel their membership or the member will be responsible for all dues between the reinstatement date of the freeze and the cancellation effective date.

Member Signature

Date

FOR OFFICE USE ONLY						
BALANCE AT TIME OF FORM COMPLETION (Not final)			STATUS CHANGE DATE			
CURRENT BALANCE	ADJUSTMENTS \$	TOTAL DUE \$	Date of original request			
Form sent to: email			Monthly Rep/Members			