For Office Use Only
Date _____ Type of Membership _____ Amt. Pd. _____ Exp. Date _____

Wellness Plus Membership Agreement

Name _____ (if married) Spouse's Name_____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell#_____ E-mail*_____

**unless otherwise instructed by you, we will send our monthly calendar of events to you via e-mail. We will not share your e-mail address with other organizations without your express permission.*

Referred by _____

Medical Problems _____

Medications _____

Smoker Y N

Allergies to medicines or other allergies _____

(If children at home) Names and Ages _____

Agreement:

I have decided to take control of my health and become a member of Wellness Plus Delaware. I understand that my whole family will enjoy all the benefits of this membership. My fee will remain at the current rate as long as I renew my membership on time. Late renewal fee is $5 per month. I will receive $1 off my renewal for every 1% of body fat that I lose up to $30 or when I reach my goal, whichever applies. ***My body fat goal is:***

- 27% for *women* and 23% for *men* **over** 30
- 24% for *women* and 20% for *men* **under** 30

I am entitled to free one-on-one consultations to answer any questions or concerns about my health. Call us at **302-478-7723**.

Membership Fees (2022):

Family **Annual $459 ($44 monthly installments)**
Business **Annual $479 ($47 monthly installments)**

Date _____My height _____ My weight _____ My body fat % _____

Signature _____