**Owned and Operated by St. Andrews Fitness Corporation**

| Columbiana Point | Lexington | Forest Acres | Sandhills | Killian Road |
|---|---|---|---|---|
| 800 Columbiana Drive | 619 N. Lake Drive | 4114 Forest Dr | 226 Forum Drive | 450 Killian Rd |
| Irmo, SC 29063 | Lexington, SC 29072 | Forest Acres, SC 29206 | Columbia, SC 29229 | Columbia, SC 29203 |

# MEMBERSHIP CANCELLATION POLICY

It is always our desire that you will be able to use your membership to the very last day of your term; however, we are aware that circumstances may prevent you from doing so. The following information is provided to clarify our policy on membership cancellation and to assist you in expediting the process in the event that you must cancel.

1. **MONTH-TO-MONTH memberships** – if you have a month-to-month membership, you only need to give a 30 day notice to cancel your membership. Any regularly monthly payments that happen to fall within that 30 day period will be drafted.

2. Your membership contract may be cancelled if you **have or will be permanently relocating** to a residence 50 miles or further from any of the müv fitness locations listed above. Submit the filled out cancel request form along with one of the following for proof of relocation:
   **Acceptable proof:**
   - Lease agreements – 1st and last page
   - Deed
   - Utility Bills – must be in members name (excludes cell phone bill)
   - Student schedules – must show college name, members name and current schedule dates
   - Military orders
   - Letters from the employer on company letterhead stating the relocation
   - Paystubs – must show members name, new address and recent date on paystub
   - ***International use only** – One way airline tickets, **if you do not have one of the above**.

2. Your membership contract may be cancelled in the event of a **Substantial Physical Disability**, attached (page 3) is the form that your physician needs to fill out and sign.

3. Your membership contract may be cancelled by your estate **in the event of your death.** Within 30 days, please have someone submit a copy of the death certificate or obituary notice.

**If none of the above circumstances apply to you, your membership contract is not eligible for cancellation.**

If any of the above circumstances do apply to you, complete "Membership Cancellation Request" or "Substantial Physical Disability" form and submit it to the address on the forms. **If you also have a Personal Training contract please check that on the form.**

**THE 30 DAY CANCELLATION NOTICE PERIOD WILL BEGIN UPON RECEIPT OF ALL REQUIRED DOCUMENTATION AND YOUR MEMBERSHIP WILL BE CANCELLED AT THE END OF THE 30 DAYS. ANY MONTHLY PAYMENTS THAT FALL WITHIN THE 30 DAY NOTICE PERIOD MUST BE PAID BEFORE MEMBERSHIP WILL BE CANCELLED.**

**Before a cancellation is approved the following will be verified:**

1. **All information provided in support of your cancellation request is true and accurate**
2. **All fees are paid current to the effective cancellation date**

**The burden of proof rests with the member. müv fitness reserves the right to deny cancellation in the absence of appropriate documentation or non-compliance with this cancellation policy.**

REV. 12/1/15

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## MEMBERSHIP CANCELLATION REQUEST

______ **3 DAY CANCEL (new memberships cancelled within 3 business days)**

______ **RELOCATION CANCELS**

______ **MONTH-TO-MONTH 30 DAY NOTICE CANCEL**

______ **ALSO HAVE PERSONAL TRAINING CONTRACT**

**ALL RELOCATION AND MEDICAL CANCELLATIONS REQUIRE 30 DAYS NOTICE.**

**ANY SCHEDULED MONTHLY DRAFTS THAT FALL WITHIN THE 30 DAYS ARE REQUIRED TO BE PAID. ALL ACCOUNTS MUST BE PAID CURRENT TO QUALIFY FOR CANCELLATION. PROOF PROVIDED MUST MEET THE ALLOWABLE CIRCUMSTANCES AS STIPULATED ON YOUR SIGNED MEMBERSHIP AGREEMENT UNDER "MEMBER'S RIGHT TO CANCEL" CLAUSE, AND AS LISTED ON PAGE 1 OF THIS DOCUMENT.** Please complete **ALL** of the appropriate sections.

**PERMANENT RELOCATION:**
I request that my membership contract be cancelled due to my permanent relocation to:

Street Address ______________________________

City, State, Zip ______________________________

Telephone ______________________________

**I have attached acceptable proof for relocation and I have read and understand the Membership Cancellation Policy of müv fitness Columbia.**

Member Name (Print)____________________Member Signature ________________________

Member Barcode No.____________________Date________________________

MAIL TO: **ABC FINANCIAL CUSTOMER CARE**
**P.O. BOX 6800**
**SHERWOOD, AR 72124**

EMAIL TO: customercare@abcfinancial.com

FAX TO: **501-992-0802**

______________________________ **Date** ____________________
**ABC Rep Signature**

REV. 12/1/15

# CANCELLATION OF MEMBERSHIP DUE TO SUBSTANTIAL PHYSICAL DISABILITY

| Columbiana Point | Forest Acres | Lexington | Sandhills | Killian Road |
|---|---|---|---|---|
| 800 Columbiana Drive | 4114 Forest Drive | 619 N. Lake Drive | 226 Forum Drive | 450 Killian Road |
| Irmo, SC 29603 | Forest Acres, SC 29206 | Lexington, SC 29072 | Columbia, SC 29229 | Columbia, SC 29209 |

***THIS FORM HAS TO BE FILLED OUT AND SIGNED BY PHYSICIAN.***

MAIL TO: **ABC FINANCIAL CUSTOMER CARE**
**P.O. BOX 6800**
**SHERWOOD, AR 72124**

EMAIL TO: customercare@abcfinancial.com
FAX TO: **501-992-0802**

**Date: ________________ Member Barcode#____________________ Member Phone#______________**

**ST. ANDREWS FITNESS CORPORATION d/b/a müv fitness**

**NOTICE OF CANCELLATION (SUBSTANTIAL PHYSICAL DISABILITY)**

Member Name: ____________________ Member Address: ______________________________________

I, the undersigned, desire to cancel my membership agreement with St. Andrews Fitness Corporation d/b/a müv fitness ("SAFC") because I have developed a substantial physical disability which makes it permanently impossible for me to use the SAFC services. I understand that my membership agreement will not be cancelled until I deliver to SAFC a written statement for a physician in which the physician certifies that I have a substantial physical disability which makes it permanently impossible for me to use the SAFC services.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by federal privacy regulations, including the Health Insurance Portability and Accountability Act. I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

Persons/Organizations providing the information: ______________________________________________

Specific description of information covering health care: Evidence showing that I have a substantial physical disability which makes it permanently impossible for me to use the SAFC services.

This information may be disclosed to and used by the following organization for the purpose of substantiating whether I have a substantial physical disability which makes it permanently impossible for me to use the SAFC services.

_____________________________________ _________________________________
Signature of Member Date

_____________________________________
Signature of Witness

**PHYSICIAN CERTIFICATION**

I, the undersigned, a physician licensed to practice medicine in the State of _________________________, do hereby certify to St. Andrew Fitness Corporation d/b/a müv fitness that the person named above has a substantial physical disability which makes it permanently impossible for such person to use the SAFC services.

Physician Signature:______________________________ Date:____________________________

Physician Name(print):____________________________ Physician License#:_________________________

Physician Address & Phone#:_________________________________________________________________

REV. 12/1/15