

# Membership Changes & Cancellation Request Form

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER



## MEMBER INFORMATION

Please complete top portion, and fill out appropriate section for your change/cancellation request.

### PRIMARY ADULT

NAME (FIRST, MIDDLE, LAST)

CELL WORK PHONE EMAIL

BIRTHDATE  MALE  FEMALE MEMBERSHIP CARD #

### HOUSEHOLD INFORMATION: ADDRESS

CITY STATE ZIP HOME PHONE

## I WOULD LIKE TO UPDATE MY INFORMATION

Please enter new information below in applicable section.

NAME (FIRST, MIDDLE, LAST)

CELL WORK PHONE EMAIL

BIRTHDATE  MALE  FEMALE MEMBERSHIP CARD #

### HOUSEHOLD INFORMATION: ADDRESS

CITY STATE ZIP HOME PHONE

## I WOULD LIKE TO SUSPEND MY PAYMENTS

OUT OF TOWN STUDENT  MEDICAL EMERGENCY  TRAVEL  \_\_\_\_\_

Proof of additional residence, student status or medical release is required. Please attach to form.

EXPECTED DATE OF RETURN (MM/YY) AUTOMATIC PAYMENTS TO START ON THE 20TH OF (MM/YY)

MEMBER SIGNATURE DATE

## I WOULD LIKE TO CHANGE MY MEMBERSHIP TYPE OR ADD/REMOVE MEMBER(S) ON MY ACCOUNT

Membership downgrades and removal of family members are subject to a \$20 change fee.

PLEASE SELECT YOUR CURRENT MEMBERSHIP TYPE(S):

ADULT  SENIOR  YOUTH  FAMILY I (UP TO 5 MEMBERS)  FAMILY II (6 MEMBERS OR MORE)

PLEASE SELECT YOUR NEW MEMBERSHIP TYPE(S):

ADULT  SENIOR  YOUTH  FAMILY I (UP TO 5 MEMBERS)  FAMILY II (6 MEMBERS OR MORE)

I WOULD LIKE TO ADD/REMOVE THE FOLLOWING INDIVIDUAL(S) TO MY FAMILY MEMBERSHIP:

REASON FOR REMOVAL:

MOVED  MEDICAL  NO TIME  FEES TOO HIGH  FACILITY TOO CROWDED  DISSATISFIED WITH STAFF  OTHER \_\_\_\_\_

NAME (FIRST, MIDDLE, LAST)  ADD  REMOVE

BIRTHDATE (MM/DD/YY) RELATIONSHIP TO PRIMARY ADULT  MALE  FEMALE

NAME (FIRST, MIDDLE, LAST)  ADD  REMOVE

BIRTHDATE (MM/DD/YY) RELATIONSHIP TO PRIMARY ADULT  MALE  FEMALE

NAME (FIRST, MIDDLE, LAST)  ADD  REMOVE

BIRTHDATE (MM/DD/YY) RELATIONSHIP TO PRIMARY ADULT  MALE  FEMALE

PLEASE PROCEED TO SIDE 2.

FOR OFFICE USE ONLY:

CHANGE REQUEST  PAYMENT SUSPENSION  BANK CHANGE REQUEST  CANCELLATION

ENTERED BY

DATE

NOTES:

## I WOULD LIKE TO CHANGE MY BANKING INFORMATION

To change to a new bank account or credit card, a new Authorization Agreement for direct payments must be completed and signed.

### OPT 1: AUTOMATIC MONTHLY ON VISA/MASTERCARD

I authorize The Salvation Army Ray and Joan Kroc Corp Community Center ("Kroc Center Hawaii") to charge my credit card monthly indicated below. This is an automatic withdrawal system where payment of membership dues are regularly charged to the member's bankcard the 20th of each month or the next business day.

VISA       MASTERCARD       AMEX       DISCOVER

NAME (AS IT APPEARS ON CARD)

SIGNATURE

DATE

### OPT 2: MONTHLY ELECTRONIC FUNDS TRANSFER

By signing, I give Kroc Center Hawaii authorization to deduct monthly dues directly from the listed bank account at my financial institution. Kroc Center Hawaii also reserves the right to deduct any amount past due from the same account. I understand that all debits from my bank account will be conducted on the 20th of each month regardless of date joined. Any debit request in process at the time we receive the notice of termination of authority will be completed. This authorization is to remain in full force and effect until Kroc Center Hawaii has received written notification from me of its termination in such time and in such manner as to afford Kroc Center Hawaii and any involved financial institutions a reasonable opportunity to act on it (minimum of 15 business days).

NAME OF BANK ACCOUNT HOLDER

BANK NAME

ACCOUNT #

TRANSIT/ABA NO. (FIRST 9 DIGITS ON CHECK)

SIGNATURE

DATE

Please provide voided check with change form.

## I AM REQUESTING TO CANCEL MY MEMBERSHIP AND DIRECT MONTHLY AUTO PAYMENTS

I am the signer of the Authorization Agreement for Direct Payments. I understand I must submit a written request to cancel a membership and to discontinue the corresponding debit entry/entries to my (our) checking/savings account on record with the Kroc Center Hawaii accounting department by the **10th of the current month** in order to become effective in the following month. If I elect to reopen my membership(s), the appropriate registration fee will apply.

NAME OF BANK ACCOUNT HOLDER

### LIST OF ALL MEMBER(S) TO BE CANCELLED:

NAME (FIRST, MIDDLE, LAST)

NAME (FIRST, MIDDLE, LAST)

NAME (FIRST, MIDDLE, LAST)

NAME (FIRST, MIDDLE, LAST)

SIGNATURE OF BANK ACCOUNT HOLDER

DATE

REASON FOR LEAVING:

MOVED       MEDICAL       NO TIME       FEES TOO HIGH       FACILITY TOO CROWDED       DISSATISFIED WITH STAFF       OTHER \_\_\_\_\_

FACILITIES INADEQUATE: (PLEASE DESCRIBE)

PROGRAMS INADEQUATE: (PLEASE DESCRIBE)

JOINED ANOTHER FACILITY: (WHICH)

DO YOU HAVE ANY CHILDREN CURRENTLY ENROLLED IN KROC CENTER PROGRAMS?       YES       NO

DO YOU KNOW ABOUT OUR FINANCIAL ASSISTANCE SCHOLARSHIP PROGRAM?       YES       NO

WOULD YOU LIKE SOMEONE TO CONTACT YOU ABOUT SCHOLARSHIPS?       YES       NO

DID YOU FIND OUR STAFF HELPFUL AND KNOWLEDGEABLE?       ALWAYS       SOMETIMES       RARELY

DO YOU HAVE COMMENTS OR SUGGESTIONS THAT MIGHT HELP US TO SERVE YOU BETTER?

*This form serves as an addendum to the original Membership Form. The original Terms of Membership apply to all members, including any members added on this Membership Changes & Cancellation Request Form. By signing this form, I agree that I have read and understand Kroc Center Hawaii's Terms of Membership.*

MEMBER SIGNATURE

DATE

CHANGE/CANCELLATION WILL TAKE EFFECT ON:

TODAY'S DATE

MEMBER INITIALS

EMPLOYEE INITIALS

