Prescription Club enrollment form

Subscriber information: (please print) -- *indicates required information

*First Name	MI	*Last Name	Person code 01	*Date of birth (MM/DD/YYYY)
*Mailing address		*City	*State	*Zip
*Phone Number	Email address			Customer status New Existing

First name	MI	Last name	Person code 02	Date of birth MM/DD/YYYY	Relationship
First name	MI	Last name	Person code 03	Date of birth MM/DD/YYYY	Relationship
First name	MI	Last name	Person code 04	Date of birth MM/DD/YYYY	Relationship
First name	MI	Last name	Person code 05	Date of birth MM/DD/YYYY	Relationship
First name	MI	Last name	Person code 06	Date of birth MM/DD/YYYY	Relationship

Terms: This pharmacy savings program, the Prescription Club, is administered by Medical Security Card Company (MSC), LLC of Tucson, Arizona. In administering the Prescription Club program, MSC receives protected health information (including but not limited to the information provided on this enrollment form) from Prescription Club transactions submitted by participating provider pharmacies or directly from you. Your authorization is required as a condition of enrollment in Prescription Club program as MSC must have this information to administer its point-of-sale discount service. The protected health information provided to MSC and any provider pharmacy for purposes of administration of the Prescription Club program is not transferred, sold or otherwise disclosed to third parties, except as necessary for the proper administration of the Prescription Club program, or as may be otherwise required by law, and is always protected as Confidential Private Information. For additional information, including the Notice of Privacy Practices for participating providers, please visit www.myleaderprescriptionclub.com. To view the MSC Privacy Policy, please visit: www.scriptsave.com/en/privacy.aspx.

Authorization: I understand that my signature on this enrollment form constitutes my written authorization for MSC to receive and use the protected health information described above for the proper administration of the Prescription Club program in accordance with applicable law. I understand that if my medical information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives my medical information and this re-disclosure may not be protected by the applicable privacy laws. This authorization shall remain in effect for the duration of my enrollment in the Prescription Club. I have the right to revoke this authorization in writing at any time by contacting Medical Security Card Company, LLC at 4911 E. Broadway Blvd., Tucson, AZ 85711, except to the extent that my medical information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of this program, my revocation of this authorization shall result in cancellation of my enrollment in the Prescription Club program.

*Authorization signature: _____ Date: _____

Printed name: _____

Additional Health Savings information: Pursuant to your enrollment in the Prescription Club, MSC and your pharmacy may also provide you with special information to enhance your health, such as drug price comparisons, and/or special savings opportunities (Additional Health Savings Information) through programs administered by MSC and/or pharmacy. Your signature below constitutes your written authorization for MSC and your pharmacy to provide you with Additional Health Savings Information by regular mail or by email at the addresses indicated above. You may opt out of receiving future transmissions of Additional Health Savings Information by contacting your participating pharmacy. If you are signing on behalf of dependent family members, your signature verifies that you are the parent/legal guardian or the authorized representative of the individuals identified above.

Authorization signature: _____ Date: _____

Right to Receive Copy of This Authorization: I understand that I have a right to receive a copy of this signed authorization upon request.

PHARMACY USE ONLY

Patient Is Participating In: 933

Enrollment fee amount: $_____

Processing Information: RxBIN: 015715 RxPCN: SS

Pharmacy name: _____

Address: _____

Phone: _____

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CUSTOMER KEEPS THIS PAGE

Terms & Conditions
The Prescription Club (Program) and use of the services is subject to the following terms and conditions. Please read these terms and conditions carefully before completing your enrollment in the program, so that you fully understand your rights and responsibilities.

Disclosures
This discount program is NOT a health insurance policy or a Medicare prescription drug plan and is not intended as a substitute for insurance. The program does not qualify as minimum creditable coverage under Massachusetts law. The program only provides for discounts on select prescription medications purchased from a participating pharmacy. The range of the discounts may vary depending on the pharmacy and the medication purchased. The program does not make payments to providers of health care services. Members are required to pay for all health care services, but will receive a discount from contracted pharmacies. Prescriptions paid for in whole or in part by private or publicly funded health care programs, such as Medicare and Medicaid, are ineligible. Any prescriptions covered in whole or in part by private or publicly funded insurance will be processed through that insurance unless the patient specifically requests that the prescription be processed through the Prescription Club. There is no secondary coverage or coordination of benefits for prescriptions filled under the Prescription Club. Participating pharmacies are subject to change without notice and are not available in all areas. Discounts cannot be combined with any insurance. This program is administered by Medical Security Card Company, LLC (MSC), 4911 E. Broadway Blvd., Tucson, AZ 85711, 1-800-700-3957, www.scriptsave.com and is marketed by Cardinal Health, Inc.

Benefits
To obtain discounts, present your membership card at a participating pharmacy before you pay for any prescription drugs. The Program provides access to over 300 generic medications at a discounted flat rate* for 30 and 90 days' supply1 ; extended discounts for more than 5,000 brand and generic prescription medications (excluding controlled substances); discounts on human equivalent pet medications and special rates for select** immunizations received at your pharmacy.

*The Program, as well as the prices and the list of drugs can be modified at any time without notice
**Please see the pharmacist for a list of immunizations and prices
[1]The day supply is based on the average dispensing patterns for the specific drug and strength

Fees & Term of Agreement
An annual enrollment fee of $10 is payable at ti me of enrollment and the Program is effective immediately upon receipt of enrollment fee and signed enrollment form. You will be assessed the annual fee every year at ti me of renewal when presenting for services at participating pharmacy. The program expires 30 days from the annual renewal date should the annual renewal fee not be paid. There is no waiting period for accessing services under the Program once enrollment and fee have been received.

Household Membership
Members of your household are members of this Program. A household member includes any person, or pet residing in your household. Family members not initially enrolled may be added to the Program by visiting the pharmacy to add that family member to your existing member records.

Limitations
This program is not available in all states. This program is governed by the terms of the membership agreement provided upon enrollment. Administrator is not responsible for providing or guaranteeing service or for the quality of service rendered. This contract is not protected by any state guaranty fund.

Cancellation and Termination
If you are not completely satisfied, you may call or email us to cancel at any time. Your membership will terminate at the end of the billing cycle for which you have paid, and you will not be billed further.

Contacting Us/Complaint & Resolution
If you have any other questions or concerns regarding these Terms & Conditions, or complaints regarding the Program, please contact us as follows:

Via Mail at: Medical Security Card Company, LLC 4911 E. Broadway Rd., Ste. 100 Tucson, AZ 85711
Or Via E-Mail at: customercare@scriptsave.com Or Via Phone at: 1-800-700-3957

A Customer Care Representative will take note of your question or concern and forward it promptly to the appropriate party. We will respond to any complaint within 5 business days. If you remain dissatisfied with the outcome of a complaint, you may contact the appropriate governmental regulatory agency in your state. Information for your state's regulatory agency can be obtained by contacting us via phone or email.