Prescription Club enrollment form

Subscriber information: (please print)

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

Dependents covered in addition to subscriber: (please print)

First name	MI	Last name	Person code	Date of birth (MM/DD/YYYY)	Relationship
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

HIPAA Authorization

Terms. This prescription drug discount program the "Prescription Club" is administered by Medical Security Card Company (MSC) of Tucson, Arizona. In administering the Prescription Club, MSC receives individually identifiable health information (including but not limited to the information provided on this enrollment form) from your participating pharmacy as listed below or directly from you. Your authorization is required as a condition of enrollment in the Prescription Club as MSC must have this information to administer its point-of-sale discount prescription service. The individually identifiable health information provided to MSC and pharmacy is not transferred, sold or otherwise disclosed to third parties, except as necessary for the proper administration of the Prescription Club or as may be otherwise required by law, and is always protected as Confidential Private Information. If your medical information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives your medical information and this re-disclosure may not be protected by the applicable privacy laws. For additional information, including the pharmacy privacy policy, please ask the pharmacist.

Authorization. I understand that my signature on this enrollment form constitutes my written authorization for MSC to receive and use the individually identifiable health information described above for the proper administration of the Prescription Club in accordance with applicable law. 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 to my participating pharmacy at any time 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. 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.

Members shall pay an annual fee of $10 for individual or for family. Family includes spouse and dependents under the age of 23. Cards for other adult family members, such as parents or grandparents, will require an additional enrollment fee. Persons receiving benefits from a publicly funded health care program are ineligible for the the Prescription Club. By enrolling in the Club you are affirming that you are not a recipient of benefits from a publicly funded program. The Prescription Club is not insurance or an insurance benefit, nor is it intended as a substitute for insurance.

Authorization Signature: ______________________________ Date: ______________

Printed name: ______________________________

Additional Health Savings Information: Pursuant to your enrollment in the Prescription Club, MSC and 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 pharmacy to provide you with Additional Health Savings Information as described above. You may opt out of receiving future transmissions of Additional Health Savings Information by contacting your participating pharmacy.

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 (Select Only One): Please check the box below

☐ 933A ☐ 933B ☐ 933C ☐ 933D ☐ 933E ☐ 933F ☐ 933G

Enrollment fee amount: $______________

Pharmacy name: ______________

Address: ______________

Phone: ______________