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	

Dependents covered in addition to subscriber: (please print)

First name	MI	Last name	Person code	Date of birth	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

Terms: This pharmacy savings program, the Prescription Club, is administered by Medical Security Card Company, LLC (MSC) 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 (Select Only One): Please check the box below

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

Enrollment fee amount: $______________________

Rx Processing Information: RxBIN: 015715 RxPCN: SS

Pharmacy name: ______________________

Address: ______________________

Phone: ______________________