

PRESCRIPTION SAVINGS CLUB ENROLLMENT FORM



Joining is Easy

1. Complete the enrollment form below.
2. Pay the \$5.00 Annual Membership Fee.
3. Begin using the program today.

Pricing

30-day generic drug prescription—\$4.99*

90-day generic drug prescription—\$11.99*

* Ask your pharmacist for a list of generic medications included in the Prescription Savings Club. Discounts are also available on other generic and brand name medications. The days' supply is based upon the average dispensing patterns for the specific drug and strength. The program, prices, and the list of covered drugs may be modified at any time without notice.

Enrollment Form (ALL fields are required for processing.)

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____ Email: _____

Terms: The program membership is per person. The yearly enrollment fee of \$5.00 per person provides you all of the advantages of the *Prescription Savings Club* program. The Prescription Savings Club program treats all HIPAA Protected Health Information in accordance with federal guidelines. A copy of our Notice of Privacy Policy is available from your pharmacist.

Authorization: I understand that my signature on this enrollment form constitutes my written authorization for my pharmacy to charge me an annual \$5.00 membership fee and enroll me in the Prescription Savings Club program.

Member Signature: _____ Date: _____

Disclosures: This discount program is NOT a health insurance policy and is not intended as a substitute for insurance. This program only provides for discounts on health services from participating pharmacies. This 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 the participating pharmacy. This program does not make payments directly to any provider; you are obligated to pay for all services at the time of the service. Membership and activation fees apply. This program is governed by the terms outlined in this enrollment form. Prescriptions paid for in whole or in part by publicly funded health care programs, such as Medicare and Medicaid, are ineligible. Membership discount cannot be combined with any insurance.

Cancellation and Termination: You may cancel your membership in this program at any time. To cancel your membership in this program, contact your local pharmacy and inform them of your choice to no longer participate in the *Prescription Savings Club*.

Contacting Us: If you have questions about this program, please contact your participating pharmacy.

Processing Information (For Office Use Only)

Annual membership fee enrolls the patient in both of the below plans:

PLAN: AFS Low Cost Generic

Rx BIN: 008556

Rx PCN: DSCPLN

ID: 10-digit phone + 2-digit birth order (e.g. 80155555501): _____

Discount Plan: AFS Discount Card

Rx BIN: None

RX PCN: None

ID: 10-digit phone + 2-digit birth order (e.g. 80155555501): _____

THIS IS NOT AN INSURANCE PLAN

