



# Program Enrollment

P. O. Box 460  
Avon, Ohio 44011  
www.rxanswer.net

## MEMBER INFORMATION (please print)

NAME: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_  
Area Code

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  Male  Female

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

## SPOUSE INFORMATION

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

SOCIAL SECURITY # \_\_\_\_\_  Male  Female

## DEPENDENT INFORMATION

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

SOCIAL SECURITY # \_\_\_\_\_  Male  Female

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

SOCIAL SECURITY # \_\_\_\_\_  Male  Female

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

SOCIAL SECURITY # \_\_\_\_\_  Male  Female

As a member of RxAnswer membership program we understand that your trust in us is one of our most important assets. In order to preserve that trust, we want you to understand our information practices and your rights to ask us not to share certain information about you. As a member of this program we want you to know the following:

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

RxAnswer designated pharmacy benefit administrator may use, without consent, de-identified information solely for purposes of billing pharmaceutical manufacturers who participate in this program to help reduce your cost. This information does not contain any personal information which might be used to identify you.

Upon enrollment you will receive a **Member Enrollment Kit** including a preferred drug list, a personalized plastic identification card and answers to frequently asked questions.

*I hereby apply for membership enrollment in RxAnswer Prescription Drug Program. I understand that acceptance of this application of membership is guaranteed and that the following effective dates apply: if my application is received by the 20th of the month, my effective date will be the 1st of the following month; if my application is received after the 20th of the month, my effective date will be the 1st of the month after next month. I understand that by participating in this program external factors may force a change in monthly fee, benefits or preferred drug list at any time. I will be entitled to negotiated and funded discounts on eligible prescription drugs purchased from any participating pharmacy.*

<b>Enrollee Signature</b>	<b>Date</b>

*Signature authorizes release of information and enrollment into the Program*



# Enrollment Application

P. O. Box 460  
Avon, Ohio 44011  
www.rxanswer.net

## 1. CHOOSE A MONTHLY PAYMENT PLAN:

- \$16.95 for Single       \$21.95 for Family (2 or more)

## 2. CHOOSE A PAYMENT METHOD:

- Check/Money Order - payable to RxAnswer
- Electronic Bank Draft (EFT/ACH) - complete authorization below  
*(MOST CONVENIENT CHOICE)*
- Credit Card: VISA or MASTERCARD - complete authorization below

**\*IMPORTANT:** Regardless of payment choice the first months premium must be paid by check and included with this application.

I hereby authorize RxAnswer to charge/draft my credit card (listed below) or draft my checking/savings account from the financial institution (listed below on my enclosed voided check). I agree that if any charge is dishonored, whether intentionally or inadvertently, RxAnswer shall be under no liability whatsoever. This authority is to remain in effect until RxAnswer receives written notification from me revoking the authorization.

For Credit Cards ONLY:

Credit Card Number: \_\_\_\_\_

Type of Card:  VISA     MASTERCARD    Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

m m    d d    /    y y    y y

CVV2 Code: \_\_\_\_-\_\_\_\_-\_\_\_\_    This is the three digit code located on the back of your credit card. **It is required.**  
This application will be stored electronically with the CVV2 code removed and the original app will be destroyed.

For Electronic Bankdrafts EFT/ACH ONLY:

Name of Financial Institution: \_\_\_\_\_ (Draft Date Will Be Around The 15th)

Financial Institution Routing Number: \_\_\_\_\_

Financial Institution Account Number: \_\_\_\_\_

For **BOTH** Credit Cards and Bankdrafts:

Signature of Account Holder (or POA) \_\_\_\_\_

## PLEASE INCLUDE A VOIDED CHECK FOR EFT/ACH PROCESSING

**To Avoid A Delay In Processing...**

- 1. COMPLETE APPLICATION ON REVERSE SIDE;** be sure to sign at the bottom.
- 2. SELECT COVERAGE TYPE**
- 3. SELECT PAYMENT METHOD;** be sure to add the first month's enrollment fee and fill in total payment, if necessary.
- 4. COMPLETE PAYMENT INFORMATION** for bankdraft or credit cards, if applicable.
- 5. PLEASE INCLUDE CHECK FOR FIRST MONTHS PREMIUM,** make payable to RxAnswer and mail to:  
P. O. Box 460, Avon, Ohio 44011

<b>OFFICE USE ONLY DATE RECEIVED:</b>	<b>CHECK NUMBER:</b>
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<b>CONSULTANT:</b>	<b>CONSULTANT NUMBER:</b>
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