



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

I hereby apply for membership enrollment in Rx Answer Prescription Program. I understand that acceptance of this application of membership enrollment is guaranteed, that my enrollment will become effective on the 1st day of the following month in which the application is received. I also understand that by participating in this program external factors may force a change in monthly fee, benefits and/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.

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

As a member of Rx Answer 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 plan 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."

Rx Answer 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.

If you wish to revoke the right for us to use your personal health information (PHI), you must do so in writing to Rx Answer, P. O. Box 460, Avon, Ohio 44011. Your request will be processed within 60 days upon receipt. Revoking the right for us to use your personal health information may also terminate your benefit. This is not insurance.

Enrollee Signature	Date

Signature authorizes release of information and enrollment into the Program