Apply in three easy steps.

You may also apply by phone at **1-800-444-4106** or online at **TogetherRxAccess.com**

APPLICATION FORM

Together Rx Access® Prescription Savings Program
00000 0000
MEMBER NAME

STEP 1: CHECK YOUR ELIGIBILITY

Please read the following list of eligibility requirements. If you meet all three requirements, check the box below and continue with Steps 2 and 3. Questions? Call us at 1-800-444-4106.

- I am not eligible for Medicare.
- I have no prescription drug coverage of any kind.
- I have household income equal to or less than: $45,000 for a single person; $60,000 for a family of two; $75,000 for a family of three; $90,000 for a family of four; $105,000 for a family of five.

Families of six or more and residents of Alaska and Hawaii should contact Together Rx Access at **1-800-444-4106** for household income information.

☐ **YES, I meet all three of the eligibility requirements listed above.**

STEP 2: FILL IN YOUR INFORMATION

First Name | M.I. | Last Name | M | F

Address (Street Number / Street Name / Apartment Number)

City | State | Zip Code

Telephone | Date of Birth (MM / DD / YYYY)

Email Address (optional)

Spouse or Dependent Information: You may enroll additional family members in the Together Rx Access Program if: 1) you can claim them as a financial dependent (other than a spouse) on tax returns or other government programs; 2) they are not eligible for Medicare; and 3) they do not have prescription drug coverage. If you have a spouse and/or dependent who meets these criteria, please list them below. (To enroll more dependents, please call 1-800-444-4106.)

Spouse (if eligible):

First Name | M.I. | Last Name | M | F | Date of Birth (MM / DD / YYYY)

Dependents (who meet above eligibility requirements):

First Name | M.I. | Last Name | M | F | Date of Birth (MM / DD / YYYY)

First Name | M.I. | Last Name | M | F | Date of Birth (MM / DD / YYYY)

STEP 3: SIGN THE APPLICATION FORM

I have read, understand, and accept the Program Information including the limitations and authorization to use and disclose information sections on the back of this form. I certify that the information on this enrollment form is accurate and complete. I understand and agree that an Administrator of the Together Rx Access Program may contact me in the future to verify this information.

Signature of Applicant or Representative

Today's Date (MM / DD / YYYY)

MAY WE CONTACT YOU?

By checking YES, you agree that Together Rx Access and its business partners may contact you about new programs and services, additional product and health information, or for market research purposes.

☐ YES ☐ NO

PROGRAM INFORMATION

ENROLLMENT

I understand that Together Rx Access has hired an Administrator to administer the Together Rx Access Program, who will review my enrollment form, determine my eligibility, and notify me based on the information I provide. The Administrator may at any time require additional information to determine or confirm my eligibility. If I am eligible, I will receive a membership packet and Card by mail.

LIMITATIONS

Savings under the Program do not apply to prescription products reimbursed under any federal or state program, including Medicare or Medicaid ("Government Program"), or any private insurance, HMO, Medigap, employer, or other third-party arrangement ("Private Insurance"). By signing the enrollment form, I certify that I am not, nor are any of my family members listed on this application, eligible for Medicare, and I do not have prescription drug coverage through any Government Program or Private Insurance, nor do any of my family members listed on this application.

The Card may be used only for outpatient prescription products included in the Program. Participating companies independently determine which products to include and the savings offered. Products and savings may change at any time.

The Card may not be used with other prescription discount cards or pharmacy coupons. Coupons redeemed directly by a participating company are subject to the terms and conditions of the coupon.

The Card is valid only in the US and Puerto Rico. The Program may be terminated or modified at any time.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

I understand that Together Rx Access and the Administrator will receive information about me and the prescription products that I receive using the Card. By signing this application, I authorize Together Rx Access and the Administrator to:

- use that information to administer the Program and to communicate with me, and
- share that information with participating companies for market research or analysis.

This authorization is in addition to any authorization that I have given under the heading "May We Contact You?" on the reverse side of this application. Together Rx Access does not provide/sell information that identifies you to third party companies not associated with the Program.

I may revoke this authorization by ending my participation in the Program by writing to Together Rx Access at the address provided in my membership packet.

PLEASE MAIL YOUR COMPLETED APPLICATION TO:

Together Rx Access, LLC
PO Box 9426
Wilmington, DE 19809-9944