

Enrollment Form

MEMBER INFORMATION (please print)

NAME: _____ Male Female

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

SS# _____ DOB: ____/____/____

PHONE: home: (____) _____ work (____) _____

SPOUSE INFORMATION

NAME: _____ Male Female

DOB: ____/____/____

DEPENDENT INFORMATION

CHILD 1: _____ DOB ____/____/____

CHILD 2: _____ DOB ____/____/____

CHILD 3: _____ DOB ____/____/____

I hereby apply for membership enrollment in the Prescription program. I understand that acceptance of this application for membership enrollment is guaranteed, and my enrollment will become effective upon receipt of my membership ID card. I also understand that by participating in this program external factors may force a change in the quantities, tiers and/or preferred drug list at any time.

Use of your medical information:

The designated pharmacy benefit administrator may use de-identified information solely for the purpose of billing and reporting. This information does not contain any personal information which might be used to identify you.

Please complete both parts of this application.

| | |
|--------------------|------|
| | |
| Enrollee Signature | Date |

Signature authorizes release of information and enrollment into the Program.

THIS IS NOT INSURANCE



1. PAYMENT PLAN OPTIONS (choose one)

Membership Fee PerYear

SINGLE \$49.95
One Time Enrollment Fee* \$10.00
TOTAL \$59.95

FAMILY \$69.95
One Time Enrollment Fee* \$10.00
TOTAL \$79.95

*Applicant must pay an initial one time enrollment fee of \$10.00 with first year's membership only.

2. CHOOSE A PAYMENT METHOD

Credit Card
MASTERCARD or VISA
Complete authorization below

Check or Money Order

3. MAKE CHECKS PAYABLE TO: WORx Prescription Program

4. FAX OR MAIL TO:
WORx Prescription Program
P.O. Box 408
Twinsburg, Ohio 44087-0408
Fax: 1-866-324-WORX (9679)

I hereby authorize the Company to charge any credit card as listed below for membership in the WORx Prescription Program. I agree that if any charge is dishonored, whether intentionally or inadvertently, the Company shall be under no liability whatsoever. This authority is to remain in effect until the company receives written notification from me revoking the authorization.

Credit Card Number

Expiration Date ____/____/____

Type of Card Visa MC

SIGNATURE OF ACCOUNT OR CREDIT CARD HOLDER REQUIRED HERE

Consultant: _____

Consultant ID: _____