

TrueCare Pharmacy: Family Pharmacy Cash Card Program ENROLLMENT APPLICATION

Last	First	Middle Initial	S.S.# (For I.D. Purposes Only))	Date of Birth	Date
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Street	Unit#	City	State	Zip + 4	Home Phone
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Address ()

TrueCare Pharmacy	City	State	Zip
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Other Family Members:

Name	Date of Birth	SSN#
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Name	Date of Birth	SSN#
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Name	Date of Birth	SSN#
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Name	Date of Birth	SSN#
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Insurer:

This Program offers you, the cardholder, and your dependents preferred pricing on prescription drugs from the pharmacy named above. It is not an insurance program and does not provide insurance coverage. It is administered by TrueCare Pharmacy. By accessing this preferred pricing, you acknowledge and agree that TrueCare Pharmacy may have access to and use your prescription drug data for administration of the program. Rebates paid by manufacturers on the purchase of certain preferred drugs under the program will be retained by truecare Pharmacy and this pharmacy, which makes it possible to provide you and your dependents with preferred pricing. TrueCare Pharmacy and this pharmacy reserves the right to discontinue the program in the future.

MEMBER SIGNATURE: _____