CVS CAREMARK | CAREMARK

Confidential Mail Service Enrollment Form

Please make sure that each covered dependent reads the enclosed Prescription Drug Program brochure for details on the mail service process. If you have more than 2 dependents, please submit a photocopy of this document or register online at www.caremark.com to download a form. For additional information, please call the Customer Care number that was provided to you.

This form is read by machine. Please print the numbers and letters as shown below:

1 2 3 4 A B C D

Primary Member Information

Member ID

Date of Birth M M / D D / Y Y Y Y

Daytime Telephone Number (include area code) - -

Employer / Plan Name

Last Name First Name MI

Permanent Address

Gender: Male Female

City State ZIP Code

E-mail Address

Drug Allergies: Codeine, Penicillin [01], None, Erythromycin, Sulfa [03], Aspirin [04], Iodine

Health Conditions: Diabetes [06], Heart Condition [08], Hypertension, Arthritis, Depression, High Blood Pressure [09], Thyroid-Low/High [05], Asthma, Glaucoma [07], High Cholesterol

Other / diabetic supplies _____

Dependent 1

Relationship: Spouse Child Other Gender: Male Female

Last Name

First Name MI Date of Birth M M / D D / Y Y Y Y

Drug Allergies: Erythromycin, None, Iodine, Aspirin [04], Penicillin [01], Codeine, Sulfa [03]

Health Conditions: Asthma, Depression, Heart Condition [08], High Cholesterol, Thyroid-Low/High [05], Arthritis, Diabetes [06], Glaucoma [07], High Blood Pressure [09], Hypertension

Other / diabetic supplies _____

Dependent 2

Relationship: Spouse Child Other Gender: Male Female

Last Name

First Name MI Date of Birth M M / D D / Y Y Y Y

Drug Allergies: Erythromycin, None, Iodine, Aspirin [04], Penicillin [01], Codeine, Sulfa [03]

Health Conditions: Asthma, Depression, Heart Condition [08], High Cholesterol, Thyroid-Low/High [05], Arthritis, Diabetes [06], Glaucoma [07], High Blood Pressure [09], Hypertension

Other / diabetic supplies _____

Prescription Order Form For New Participants

The enclosed prescriptions, if any, are for: (check all that apply)

Member Spouse Dependent

Please write the member number on the back of each prescription and **remember to include the prescription from the prescriber in the envelope.**

Payment Information - Credit Card

To authorize payment by credit card, provide the account number, expiration date and cardholder's signature. We accept Discover, MC, VISA and AMEX. **This card** will be used for this and all future orders, unless we are notified otherwise.

Credit Card Number Expiration Date M M / Y Y

Cardholder Signature _____ Date _____

PLEASE READ AND SIGN TO COMPLETE THIS FORM

I certify that the information provided on this form is correct and the prescriptions enclosed are for covered participants, and I authorize the release of this information to the Plan Sponsor, administrator or underwriter. **NOTICE:** All communications, including the mailing of prescriptions, will be directed to the Primary Member on the Enrollment Form. A covered dependent who wishes to receive prescriptions and communications directly instead of through the Primary Member should include a request in writing with any prescription order, or submit a Confidential Communication Form available on www.caremark.com.

Primary Member Signature _____ Date _____

Payment Information - Check or Money Order

Please make check or money order payable to **Caremark**. **Do not send cash.**

Total Amount Enclosed

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