



ENROLLMENT APPLICATION

Please print, complete and sign both pages of enrollment application and bring to your neighborhood TOPS Pharmacy.

Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Phone: () _____

TOPS **BONUSCARD** No.: _____

Email (*optional*): _____

No. Of Family Members: _____

RELATIONSHIP	NAME	DATE OF BIRTH
01. (<i>Enrollee</i>)		/ /
02. (<i>Spouse</i>)		/ /
03. (<i>Dependant</i>)		/ /
04. (<i>Dependant</i>)		/ /
05. (<i>Dependant</i>)		/ /
06. (<i>Dependant</i>)		/ /

I have read and reviewed the Terms and Conditions on the reverse side of this application, signed where indicated, and hereby agree to these Terms and Conditions by signing below.

Name: _____ Date: / /

HIPAA Authorization

Terms. This prescription drug discount program, \$3.99 Generics Program, is administered by Medical Security Card Company (MSC) of Tucson, Arizona. In administering the \$3.99 Generics Program, MSC receives individually identifiable health information (including but not limited to the information provided on this enrollment form) from TOPS Pharmacy, the pharmacies processing \$3.99 Generics Program transactions or directly from you. Your authorization is required as a condition of enrollment in the \$3.99 Generics Program as MSC must have this information to administer its point-of-sale discount prescription service. The individually identifiable health information provided to MSC and TOPS Pharmacy is not transferred, sold or otherwise disclosed to third parties, except as necessary for the proper administration of \$3.99 Generics Program or as may be otherwise required by law, and is always protected as Confidential Private Information. If your medical information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives your medical information and this re-disclosure may not be protected by the applicable privacy laws. For additional information, including the TOPS Pharmacy privacy policy, please stop by a participating TOPS Pharmacy.

Authorization. I understand that my signature on this enrollment form constitutes my written authorization for MSC to receive and use the individually identifiable health information described above for the proper administration of \$3.99 Generics Program in accordance with applicable law. This authorization shall remain in effect for the duration of my enrollment in the \$3.99 Generics Program. I have the right to revoke this authorization in writing at any time by calling 1-800-522-2522, except to the extent that my medical information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of this program, my revocation of this authorization shall result in cancellation of my enrollment in the \$3.99 Generics Program.

If you are signing on behalf of dependent family members, your signature verifies that you are the parent/legal guardian or the authorized representative of the individuals identified above.

AUTHORIZATION SIGNATURE

DATE

Additional Health Savings Information: Pursuant to your enrollment in the \$3.99 Generics Program, MSC and TOPS Pharmacy may also provide you with special information to enhance your health, such as drug price comparisons, and/or special savings opportunities (Additional Health Savings Information) through programs administered by MSC and/or TOPS Pharmacy. Your signature below constitutes your written authorization for MSC and TOPS Pharmacy to provide you with Additional Health Savings Information as described above. You may opt out of receiving future transmissions of Additional Health Savings Information by contacting our customer service department at 1-800-522-2522.

AUTHORIZATION SIGNATURE

DATE

Right to Receive Copy of This Authorization. I understand that I have a right to receive a copy of this signed authorization upon request.

