Advant*Edge* Programs Application

Name: ____

Date of Birth: ____________ Phone: (______) ______________ Mobile: (______) ______________

Address: ____

City: ______________________________ State: __________ Zip: ______________

Email: ____

*RX*ADVANT*EDGE*

I understand that by enrolling in this program, it will allow me the opportunity to obtain discounted pricing off of normal cash prices on prescription medications.

Enroll in *Rx*Advant*Edge*: ❑ Yes ❒ No

REFILL ADVANT*EDGE*

I understand that by enrolling in this program, it will allow me the opportunity to obtain automatic refills on prescription medications.

Enroll in Refill Advant*Edge*: ❑ Yes ❒ No

(Only include information for medications you would like included in Refill Advant*Edge*)

❑ All eligible medications
❑ Only the following medications (please include medication name or prescription number)

____

____

____

____

Preferred means of communication (select all that apply): ❒ Phone ❒ Text ❒ Email

Applicant Signature: ______________________________ Date: ______________

Print Name: ____

Automatic refilling of prescriptions is not allowed under Federal and State Programs where applicable.

Information will not be shared with third parties.

RxAdvantEdge is a Membership Program only. It is not insurance. Members are required to have their ID card at the time of purchase.

09/2013