



ENROLLMENT CARD

PLEASE TYPE OR PRINT WITH BALLPOINT PEN.

Group Name: _____ **Group #** _____

NAME OF EMPLOYEE - LAST	FIRST	MIDDLE INITIAL	SEX	DATE OF BIRTH	DATE OF HIRE (FULL-TIME)
			M <input type="checkbox"/> F <input type="checkbox"/>	Mo/ Day/ Yr.	Mo/ Day/ Yr.
SOCIAL SECURITY #	ADDRESS		CITY	STATE	ZIP CODE
SPOUSE NAME - LAST	FIRST	DOB		SEX	
CHILD(REN) NAME - LAST, FIRST	DOB	SEX	CHILD(REN) NAME - LAST, FIRST	DOB	SEX
_____	_____	_____	_____	_____	_____
Dependent children covered to age 25					
COVERAGE TYPE:		<input type="checkbox"/> Employee <input type="checkbox"/> Family		Premium Amount _____	
<p>I do hereby request to be covered and to authorize deductions if any, from my compensation for my share of the cost of the benefits to which i may be entitled under the prescription card issued to me. I understand that my card will not become effective until the card has been activated. i also understand that my coverage will terminate if premiums are no longer remitted through my group plan. I realize that this coverage is not an insurance product and that prices and tiers are subject to change without prior notice.</p>					
_____				_____	
EMPLOYEE SIGNATURE				DATE	
See Reverse Side →					

I hereby apply for membership enrollment _____ Prescription Program. I also understand by participating in this program, external factors may force a change in monthly fee, benefits and/or preferred drug list at any time. I will be entitled to negotiated and funded discounts on eligible prescription drugs purchased from any participating pharmacy. This is not an insured product.

Upon enrollment, you will receive a **Member Enrollment Kit** including a complete listing of preferred drug list at our website, a personalized identification card and answers to frequently asked questions.

As a member of _____ Company membership program, we understand that your trust in us is one of our most important assets. In order to preserve that trust, we want you to understand our information practices and your rights to ask us not to share certain information about (HIPAA). As a member of this plan, we want you to know the following: **“THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.”**

TAG INC. designated pharmacy benefits administrator may use, without consent, de-identified information solely for purposes of billing pharmaceutical manufacturers who participate in this program to help reduce your cost. This information does not contain any personal information which might be used to identify you.

If you wish to revoke the right for us to use your personal health information (PHI), you must do so in writing to **TAG/TMI** (421 South 9th Street, Lincoln, NE 68508). Your request will be processed within 60 days upon receipt. Revoking the right for us to use your personal health information may also terminate your benefit.