

BADGER *Rx* gold[®] program

your information

please print legibly, use black or blue ink

> name _____
first m.i. last

> address _____
number street apt. #

city state zip code

last four digits of your social security number* _____ * required to create a unique identifier for claims processing.

date of birth _____ / _____ / _____ gender M or F
mm dd yyyy circle one

telephone _____
(area code)

email address _____
(optional)

dependents

1 name _____ spouse
first m.i. last

date of birth _____ / _____ / _____ gender M or F
mm dd yyyy circle one

2 name _____ spouse
first m.i. last

date of birth _____ / _____ / _____ gender M or F
mm dd yyyy circle one

3 name _____ spouse
first m.i. last

date of birth _____ / _____ / _____ gender M or F
mm dd yyyy circle one

4 name _____ spouse
first m.i. last

date of birth _____ / _____ / _____ gender M or F
mm dd yyyy circle one

5 name _____ spouse
first m.i. last

date of birth _____ / _____ / _____ gender M or F
mm dd yyyy circle one

6 name _____ spouse
first m.i. last

date of birth _____ / _____ / _____ gender M or F
mm dd yyyy circle one

7 name _____ spouse
first m.i. last

date of birth _____ / _____ / _____ gender M or F
mm dd yyyy circle one

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cost of program

- > *annual (non-refundable) enrollment fee of \$25 per person (\$20 if enrolling online) or \$75 per family of four or more (\$70 if enrolling online)*

summary of costs

- I am enrolling as an individual. The cost per individual is \$25 per person.
of individuals _____ @ \$25 each = \$ _____*
- We are enrolling as a family of four or more (cost per family is \$75).
_____ family of four or more @ \$75 per family = \$ _____*

payment information

- > *By check: please make checks payable to NAVITUS HEALTH SOLUTIONS*

mail completed form (with payment by check)

- > *mail to: NAVITUS HEALTH SOLUTIONS, PO BOX 1031, APPLETON, WISCONSIN 54912-1031*

program information

I understand that the discounts on medications will vary based on the medication and from state to state. By presenting this card to the pharmacist with my prescription, I agree that I am authorized to use it, and that information related to prescription products purchased using the card may be collected by the pharmacy and sent to Navitus Health Solutions. The card may be used only for outpatient prescription products included in this program. Products and savings may change at any time. The card may not be used with other prescription discount cards or pharmacy coupons. The card is valid only in the United States.

My household income during the past year was (please check one):

- \$0 – \$28,000 \$28,000 – \$38,000 \$38,000 – \$58,000 over \$58,000

This information is being collected for program evaluation purposes.

authorization to use and disclose information

Navitus Health Solutions keeps all personal information confidential and private in accordance with state and federal laws. I understand that Navitus Health Solutions administers this program, and therefore will receive information about the prescription products that are purchased using the card. By signing this form, I authorize Navitus Health Solutions to use information about the prescription products that are purchased using the card to administer the program.

> _____ **signature of enrollee or representative** **date**

> _____ **spouse (if applicable)** **date**