



MERCK PRESCRIPTION DISCOUNT PROGRAM PATIENT APPLICATION FORM

Merck & Co., Inc., and its contractor (Administrator) administering the Merck Prescription Discount Program (the Program) will hold your name and personal information in strict confidence and will use it only to process your discount and administer this discount program.

COMPLETE THE PATIENT INFORMATION BELOW. PLEASE PRINT (USE BLACK or BLUE BALLPOINT PEN).

First Name _____ M.I. _____ Last Name _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____

Daytime Phone _____

Date of Birth (mm/dd/yyyy) _____ Gender Male Female Are you a US resident? Yes No

Social Security No. _____

You will be assigned a unique personal identifier in this program. If you do not provide all of the information requested in this application, we will be unable to process your application and will mail you a letter requesting that you call 1-800-50-MERCK (1-800-506-3725) to provide missing information. If you are a resident of California, you may not enroll by telephone but must enroll by mail or through the www.merckuninsured.com website.

Do you have prescription drug coverage of any kind? Yes No

(For example, Medicaid, Medicare prescription coverage, insurance company, health maintenance organization [HMO], preferred provider organization [PPO], pharmacy benefit manager [PBM], or US federal or state insurance or health assistance programs)

DEPENDENTS

You may enroll your children or other dependent family members under the age of 18 in the Program if they are US residents and they do not have prescription drug coverage of any kind (as listed above). If you have a child or other dependent who satisfies these conditions, please enter the required information below. (If your spouse would also like to participate in the Merck Prescription Discount Program, he or she should submit a separate application.)

How many dependents do you want to add? _____

Dependent 1: First Name _____ M.I. _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender Male Female

Social Security No. _____

Dependent 2: First Name _____ M.I. _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender Male Female

Social Security No. _____

Dependent 3: First Name _____ M.I. _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender Male Female

Social Security No. _____

Please check the box below if you are going to submit information for additional dependents. Please write the First Name, Middle Initial, Last Name, Date of Birth, Gender, and Social Security Number for each additional dependent on a separate piece of paper and attach it to this application form. Please write your full name on each additional piece of paper.

I am submitting information for additional dependents on a separate piece of paper and will attach it to this application form.

PROGRAM INFORMATION:

ENROLLMENT:

The Administrator of the Program will review your enrollment form, determine your eligibility, and notify you based on the information you provide. The Administrator may at any time require additional information to determine or confirm your eligibility. If you are eligible, you will receive a Welcome Membership packet and membership card by mail within approximately 2 weeks after receipt of your application.

BENEFITS:

By enrolling in the Merck Prescription Drug Program, you will receive the following:

- Discounts of 15% to 20% on many of the most widely used Merck medicines
- No age or income constraints
- Free enrollment
- No annual membership fees for the life of the program
- Discounts available at most US pharmacies

LIMITATIONS:

Savings under the Merck Prescription Discount Program do not apply to prescriptions reimbursed or covered by any federal or state program, including Medicare prescription coverage, Medicaid and state pharmaceutical assistance programs, or under any private insurance, HMO, Medigap, employer coverage, PBM, or other third-party arrangement. By signing the enrollment application, you certify that you do not have prescription drug coverage through any such government program or private insurance.

The Merck Prescription Discount Program Card may be used only for outpatient prescription drugs included in the Program. The actual discount savings could vary by pharmacy depending on the retail price of the product at a particular pharmacy. Eligible products and available discounts are subject to change at any time without notice.

The Merck Prescription Discount Program Card may not be used in combination with an Instant Savings Certificate or any other coupon or discount. The Instant Savings Certificate is available only to patients who have not enrolled in the Merck Prescription Discount Program.

The Merck Prescription Discount Program Card is valid only for United States residents obtaining prescription drugs at pharmacies located in the United States. The drugs must originate in the United States. Merck & Co., Inc., reserves the right to terminate or modify the Merck Prescription Discount Program at any time without notice. Void where prohibited. The Merck Prescription Discount Program is **not** insurance.

PLEASE NOTE: DISCOUNTS OFFERED THROUGH THE MERCK PRESCRIPTION DISCOUNT PROGRAM ARE NOT INSURANCE AND ARE NOT INTENDED TO SUBSTITUTE FOR INSURANCE.

INSTRUCTIONS TO PATIENT:

After you have filled out all required information on this application form and signed it in the 2 places required, please mail this form to: Merck Prescription Discount Program, PO Box 369, Horsham, PA 19044-9945.

PATIENT APPLICATION AND AGREEMENT TO PARTICIPATE IN THE PROGRAM:

I have read and understand the Program Information on this form relating to the Merck Prescription Drug Program (the Program). I certify that the information I have provided in this application is complete and accurate. I certify that I do not have outpatient prescription drug coverage through any insurance, employer, HMO, PBM, or government program.

I understand and agree that my name and other personal information (including personal health information about my prescriptions and those of my dependents) will be used by Administrator only for the purpose of processing discounts and administering the Program (including communication with me about the Program), unless I have specifically authorized such information to be used for other purposes.

I agree that Administrator may contact me in the future to verify or supplement any information I have provided. I understand that my participation in the Program will terminate if I do not cooperate with efforts to verify or supplement information I have provided in this application. I understand that the information I provide is necessary for Administrator to conduct data processing, mailings, and follow-up communications related to the Program. I understand that Merck & Co., Inc., reserves the right at any time and without notice to modify the application form, modify or discontinue the Program, and terminate all discounts and other assistance. I understand that completing this application does not ensure that I will qualify for the Program.

By signing below, I agree to the terms and conditions of the Program as described above.

Please sign and date.

Patient's Signature _____ Date ____/____/____

PATIENT CONSENT TO USE AND DISCLOSE INFORMATION FOR PURPOSES OF PROVIDING DISCOUNTS UNDER THE PROGRAM:

By signing below:

- I authorize the pharmacy filling my prescription to use my health information for administering the Merck Prescription Discount Program (the Program). I also authorize the pharmacy to disclose my protected health information to Administrator for the purposes stated below.
- I acknowledge and agree that, in order to receive payment under the Program, the pharmacy filling my prescription must disclose my protected health information (including my name, identifying number, prescription number, and the prescription drugs that I obtain under the Program) to Administrator.
- I understand that the pharmacy’s ability to disclose my protected health information is more fully set forth in the pharmacy’s Notice of Privacy Practices, which was provided to me when I became a customer of the pharmacy.
- I authorize Administrator to use my protected health information only for the purpose of processing discounts and communicating with me about the Program, and for all other uses necessary to administer the Program.
- I acknowledge and agree that my participation in the Program is conditioned on my signing this Consent and that I will not be able to participate in the Program if I do not sign this Consent.
- I understand that I may revoke this Consent at any time by writing to the Program at the address provided at www.merckuninsured.com. I understand that revoking this Consent will end my participation in the Program.
- I understand that once my protected health information is disclosed by the pharmacy to any other entity, the information may no longer be protected by federal privacy regulations (but may still be protected by state law).
- I understand that I may request a copy of this Consent at any time.
- I understand that this Consent will expire one (1) year after the date I sign below, unless it is earlier revoked by me or expires under operation of applicable law.

Please sign and date. (Patient must sign here to participate in the Program.)

Patient’s Signature _____ Date ____/____/____

or Signature of Personal Representative _____ Date ____/____/____

Description of Authority of Personal Representative _____

(For example, spouse, parent, adult child, power of attorney [provide copy of the legal document])