



Nobody should have to choose between buying groceries and paying for their medications. We can help.

EZMeds USA
www.yourezmeds.com

Thank you for your enrollment in EZMeds USA's pharmaceutical company "PAP" patient advocate service. We look forward to assisting you with your prescription assistance needs. **At this time, we want to make certain you understand how our service works.**

First of all, it is important to understand that you are hiring EZMeds USA as your patient advocate. We will handle all the required paperwork involved with your initial application process, any dosage changes, all refill requirements, re-applications and/or re-enrollment procedures, etc as determined by each program's sponsor. And, understanding the varying pharmaceutical company renewal procedures and timelines, it's also important for you to know that we are initiating required services for your next shipment of medication long before your current supply has been exhausted.

Patient advocacy is an ongoing procedure and, as your advocate, EZMeds will do everything necessary to ensure that you continue to receive your medication on-time, uninterrupted. **Also, please understand, you pay a monthly service fee for this advocacy, with no limit to the number of drugs you are taking.**

Because of this, do not confuse the amount of medication you receive or have on hand with the monthly service fee amount. Finally, since all of your work is done in advance your medications are shipped in 90-day supplies,

By having already submitted your Enrollment Form you've already paid your one-time, non-refundable enrollment fee and your first months service fee (\$122.00). So, on approximately the first of each following month we will debit your checking, or credit card account the monthly service (\$97.00) fee to keep your account current. (Your first debit may vary according to your enrollment date.) Please understand if you are past 30 days in paying your monthly service fees you will risk interrupting your scheduled medication shipments.

Thank you for allowing EZMEDS USA to be your patient advocate.

**Start saving money today!
Call us toll free:**

888-396-3371

EZMeds USA

1-888-396-3371

Affordable, name-brand medications are just 3 steps away!

STEP 1:

EZ MEDS ANNUAL INCOME QUALIFICATIONS

Use this list to determine the income eligibility of you and/or your family.

PERSONS IN FAMILY OR HOUSEHOLD	INCOME (48 CONTIGUOUS STATES AND D.C.)
1 (Single)	\$20,420
2	\$27,380
3	\$34,340
4	\$41,300
5	\$48,260
6	\$55,220
7	\$62,180
8	\$69,140

ALL PERSONS MUST BE A LEGAL U.S. RESIDENT



STEP 2:

Rx COVERAGE STATUS

- No Rx coverage from insurance benefit or government assistance program (e.g.: Medicaid, V.A., state assistance, etc.)
- Rx benefit has been exhausted
- Medication is specifically not covered under Rx formulary

STEP 3:

MONTHLY FEES

ONE-TIME Enrollment Fee	\$25.00
Medication Monthly Fee	\$97.00

\$25 Enrollment Fee and first months service fee due upon enrollment (\$122.00)

Name-Brand Medications, Substantial Savings

EXAMPLES OF SAVINGS EXPERIENCED BY EZMEDS USA CLIENTS

CLIENT EXAMPLE #1

MED.	DSG/QTY	ONLINE RETAIL	EZMEDS USA \$
Advair®	250/50mcg/1 disc	\$190	\$97
Lipitor®	10mg/30 tablets	\$85	\$0
Plavix®	75mg/30 tablets	\$135	\$0
Nexium®	40mg/30 tablets	\$151	\$0
Singulair®	10mg/30 tablets	\$106	\$0
Zolof®	25mg/30 tablets	\$89	\$0
TOTAL COST PER MONTH		\$756	\$97

CLIENT #1 REDUCED THEIR TOTAL MONTHLY COST BY OVER 87%, SAVING THEM \$659 PER MONTH. WITH EZMEDS USA, THEY WILL SAVE OVER \$7908 PER YEAR!

CLIENT EXAMPLE #2

MED.	DSG/QTY	ONLINE RETAIL	EZMEDS USA \$
Actos®	30mg/30 tablets	\$186	\$97
Celebrex®	200mg/30 tablets	\$190	\$0
TOTAL COST PER MONTH		\$376	\$97

CLIENT #2 REDUCED THEIR TOTAL MONTHLY COST BY OVER 74%, SAVING THEM \$279 PER MONTH. WITH EZMEDS USA, THIS CLIENT WILL SAVE OVER \$3,348 PER YEAR!

**Start saving money today!
Use this convenient form to enroll now.**



Membership Application

PATIENT INFORMATION

Name: _____ Address: _____
 City: _____ State: _____ Zip: _____ Home Phone: () _____
 Mobile Phone: () _____ E-Mail Address: _____
 Marital Status: _____ Date of Birth: _____ S.S.# _____

The best time to contact me during the work-week is in the: MORNING AFTERNOON

Are you a legal U.S. resident? YES NO

What is your annual income from all sources? _____

ALTERNATE CONTACT INFORMATION

(person assisting patient with their medications, if applicable)

Name: _____ Address: _____
 State: _____ Zip: _____ Home Phone: () _____
 Relationship to Patient: _____ Work Phone: () _____

PHYSICIAN INFORMATION

(Only list those doctors who prescribe medications listed below)

DOCTOR #1

DOCTOR #2

Name: _____	Name: _____
Facility Name: _____	Facility Name: _____
Address: _____	Address: _____
Suite: _____ City: _____	Suite: _____ City: _____
State: _____ Zip: _____	State: _____ Zip: _____
Office Phone: () _____	Office Phone: () _____

PRESCRIPTION INFORMATION (Please put the prescribing doctor # with each medication)

Dr#	Brand/Generic	Strength	Frequency

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT

I want to pay my monthly service fee by:

BANK DRAFT (IMPORTANT: You must attach a copy of your voided check)

CREDIT CARD ___ Visa ___ MasterCard

Card #: _____

Exp. Date: _____ 3-Digit Security Code: _____

EZMEDS MONTHLY SERVICE FEES

Monthly service fee: \$97.00
 One time sign up: \$25.00
 Total due with application: \$122.00
 Make check payable to: EZMeds USA

DEDUCTION AUTHORIZATION: I authorize EZMeds USA, or its designated attorney-in-fact, to electronically draft my account above or charge my credit card for my initial application fee (\$122) and \$97 monthly thereafter. This authorization will remain in full force until EZMeds USA receives written notification from me (or my designated representative) of termination of service. Please allow 30 days to process cancellation.

Authorized Signature: _____ Date: _____

Dear EZMeds USA,

I have completely filled out and am submitting the Membership Enrollment Form along with this contract. Please process it and coordinate all available medications prescribed by my doctor with all applicable services available to me.

I understand:

- that not all medications I am taking may be available through the pharmaceutical companies free drug programs.
- that pharmaceutical companies have certain criteria that must be met and that the pharmaceutical companies will make the final decision as to who qualifies for their programs.

Below are GENERAL GUIDELINES established for the pharmaceutical companies Patient Aid Programs:

Your gross yearly family income needs to be less than illustrated on the income chart. Total Gross Taxable Income includes: wages, social security, pension, disability, interest earnings, etc. (Excessive liquid assets may disqualify you from being approved for one or more medications).

You currently have no coverage (insurance or government program) that reimburses or pays for your prescription medications and you are experiencing a hardship in purchasing them.

- that I will receive a telephone (qualification) call from EZMeds to initiate qualifying me for the pharmaceutical companies' programs, and that when qualified, I will be required to provide proof of my income before any services will occur on my behalf.
- that the enclosed non-refundable \$25 enrollment and the first months fee is included with application.
- that once applications have been completed by, they will be mailed to my doctor for his/her signature. My doctor will then mail them back to EZMeds so they may be forwarded to the appropriate pharmaceutical company(s). EZMeds cannot be held responsible if applications are not returned by the doctor.
- that once the completed applications for the pharmaceutical companies PAPs (free drug programs) are returned to EZMeds it may take 6-8 weeks before I receive my first shipment of medications (generally a 90 day supply).
- that the pharmaceutical company determines whether my medication is shipped to my physician, picked up at a local pharmacy, or shipped directly to my home. Clients or EZMeds cannot decide where medications are to be delivered.
- that I am authorizing the alternate contact, if filled-in, on the Enrollment Form be approved to act on my behalf with regards to my account/records with EZMeds USA.
- I may cancel my service at any time, but no refund will be issued.
- that, with regard to the pharmaceutical companies PAPs, the facilitator acts only as a processing assistant to help me apply for and complete applications necessary to receive free drugs offered by pharmaceutical companies; they do not manufacture drugs, prescribe drugs, dispense drugs, recommend medication, or evaluate prescriptions.

I attest that the information provided in this application is complete and accurate. By my signature, I authorize EZMeds USA, LLC. to request and obtain from my healthcare provider, insurance company, or pharmaceutical company/manufacturer or its contractors any of my medical records and information, financial and insurance records and information, and/or any other information necessary for the purpose of verifying the accuracy of the information provided in this application or related to my enrollment or participation in the various pharmaceutical patient assistance programs (PAPs). I understand that any such information obtained, as well as the information provided to me in this application, will be used by EZMeds USA, LLC. and its authorized agent(s) solely to administer the PAPs and those services provided only by EZMeds USA, LLC., but will not be used or disclosed for any other purposes, except as may be required by applicable law. I understand that neither EZMeds USA, LLC. nor my healthcare provider may be held responsible in the event I provide information deemed to be fraudulent.

Please include proof of income, 2006 tax return (first page only) or Social Security income statement.



Name **X** _____ Signature **X** _____ Date **X** _____



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<p>PROVIDER:</p> <p>Agent Name: GrosJean & Associates, Inc</p> <hr/> <p>Agent Number: AZ1130</p> <hr/>
