



Prescription Delivery Service

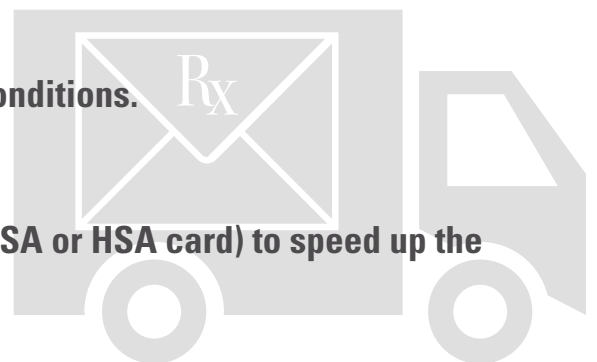
Our Prescription Delivery Service offers you convenient delivery for your medications. We recommend you use this service if you take a medication on an ongoing basis. Here's why:

- You get a two-month supply, so you don't have to refill each month.
- We'll remind you when it's time to refill, so you don't run out of your medication.
- You can easily refill your medication online or by phone.



To get started with Prescription Delivery Service, you must register on www.WellDyneRx.com. If you haven't already done this, here's how:

- 1 Go to www.WellDyneRx.com. Click on "Member Registration."**
- 2 Enter your plan information.**
- 3 Set up your account profile.**
- 4 Let us know about any allergies or health conditions.**
- 5 Provide a a payment method (credit, debit, FSA or HSA card) to speed up the ordering process.**



Get Started!

If you have questions, please visit www.WellDyneRx.com or call the Member Services number shown on your member ID card.



Prescription Delivery Service Registration Form

Please use this form to register, add dependents, or update information. Send completed form to WellDyneRx, P.O. Box 90369, Lakeland, FL 33804.

INSURANCE CARDHOLDER INFORMATION

Last Name	First Name	Middle Int	Date of Birth
Billing Address	City	State	Zip Code
Shipping Address (<input type="checkbox"/> Same as Billing Address)	City	State	Zip Code
Home Phone	Cell Phone	Email Address (to receive information about your prescription orders)	
Contact Preference (select one): <input type="checkbox"/> Email <input type="checkbox"/> Automated Phone Message			
Group Name (Primary)	Group Name (Secondary)		
Group ID#	Member ID#	Group ID#	Member ID#

ALLERGIES AND HEALTH CONDITIONS

For your safety, WellDyneRx requires allergy and health condition information for you and your dependents before dispensing medication. Please enclose additional family member information on a separate piece of paper.

Cardholder Information		Dependent Information		Dependent Information	
First & Last Name		First & Last Name		First & Last Name	
		Relationship to Cardholder		Relationship to Cardholder	
Date of Birth	<input type="radio"/> Male <input type="radio"/> Female	Date of Birth	<input type="radio"/> Male <input type="radio"/> Female	Date of Birth	<input type="radio"/> Male <input type="radio"/> Female
Drug Allergies	Health Conditions	Drug Allergies	Health Conditions	Drug Allergies	Health Conditions
<input type="radio"/> No Known	<input type="radio"/> No Known	<input type="radio"/> No Known	<input type="radio"/> No Known	<input type="radio"/> No Known	<input type="radio"/> No Known
<input type="radio"/> Amoxicillin	<input type="radio"/> Asthma	<input type="radio"/> Amoxicillin	<input type="radio"/> Asthma	<input type="radio"/> Amoxicillin	<input type="radio"/> Asthma
<input type="radio"/> Aspirin	<input type="radio"/> Bleeding Disorder	<input type="radio"/> Aspirin	<input type="radio"/> Bleeding Disorder	<input type="radio"/> Aspirin	<input type="radio"/> Bleeding Disorder
<input type="radio"/> Cephalosporins	<input type="radio"/> COPD	<input type="radio"/> Cephalosporins	<input type="radio"/> COPD	<input type="radio"/> Cephalosporins	<input type="radio"/> COPD
<input type="radio"/> Codeine	<input type="radio"/> Depression	<input type="radio"/> Codeine	<input type="radio"/> Depression	<input type="radio"/> Codeine	<input type="radio"/> Depression
<input type="radio"/> Erythromycin	<input type="radio"/> Diabetes	<input type="radio"/> Erythromycin	<input type="radio"/> Diabetes	<input type="radio"/> Erythromycin	<input type="radio"/> Diabetes
<input type="radio"/> Penicillin	<input type="radio"/> GERD/Ulcer	<input type="radio"/> Penicillin	<input type="radio"/> GERD/Ulcer	<input type="radio"/> Penicillin	<input type="radio"/> GERD/Ulcer
<input type="radio"/> Sulfa	<input type="radio"/> Heart Disease	<input type="radio"/> Sulfa	<input type="radio"/> Heart Disease	<input type="radio"/> Sulfa	<input type="radio"/> Heart Disease
<input type="radio"/> Tetracyclines	<input type="radio"/> High Cholesterol	<input type="radio"/> Tetracyclines	<input type="radio"/> High Cholesterol	<input type="radio"/> Tetracyclines	<input type="radio"/> High Cholesterol
<input type="radio"/> Other (Use space below)*	<input type="radio"/> Hypertension	<input type="radio"/> Other (Use space below)*	<input type="radio"/> Hypertension	<input type="radio"/> Other (Use space below)*	<input type="radio"/> Hypertension
	<input type="radio"/> Liver Disease		<input type="radio"/> Liver Disease		<input type="radio"/> Liver Disease
	<input type="radio"/> Renal Disease		<input type="radio"/> Renal Disease		<input type="radio"/> Renal Disease

*Please Specify Patient and Other Drug Allergies

Medication Preference: WellDyneRx will substitute generic equivalent drugs for brand medications ordered if available and permitted by your doctor. A generic drug has the same effectiveness, quality, safety, and strength, as confirmed by the FDA. Please indicate your preference for brand or generic drugs. If no box is checked, WellDyneRx will substitute generic drugs.

Substitute generic drugs if available and permitted by my doctor. I want to receive brand medications only. I understand that brand medications may be more expensive.

Signature _____ Date _____