

# Membership Application

Name \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_

I have enclosed a \$20.00 check for the initial non-refundable enrollment fee.

**Membership dues**— I authorize **ActivaRx** to deduct the \$6.00 monthly membership dues from my account. I have attached a voided check.

**Right to cancel membership**— I may cancel my membership at any time by notifying **ActivaRx** in writing. Such cancellation will become effective at the end of the month in which notification is received.

I certify that I have read and accept the provisions of **ActivaRx Drug Plan** set forth in this brochure.

### ***To avoid delay in processing—***

- **Complete and sign** this application with authorization to transfer funds.
- **Return** with voided check to ensure accurate account information.
- **Enclose** a check for \$20
- **Mail to:** 4040 E. Camelback Road, Ste. 158, Phoenix, AZ 85018
- **Questions?** Call toll free: **888-422-8482**

I hereby authorize the designated financial institution to initiate the monthly transfers from my checking or savings account as indicated by **ActivaRx**.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For office use only \_\_\_\_\_