Live Better! Wellness Club™

APPLICATION FOR CLUB AND/OR GENERIC PRESCRIPTION PROGRAM

Store # _____

Initials _____

_ _ _ _ _ _ _ _ _ _ _ (11 DIGIT#)

***Please complete and return to your Pharmacist**

(Pharmacist, please check if applicable) ☐ MAY CONTAIN MERGED DATA

The Live Better! Wellness Club™ offers its members value added services specific to their health and wellness needs. As part of the Live Better! Wellness Club™ we offer a Generic Prescription Program for individuals and families who are: (a) uninsured or (b) otherwise not utilizing prescription drug benefits for the generic drugs included in this program. A list of the generic drugs included in the program is available at the Pharmacy. All information provided by you will be kept confidential in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"). Only certified HIPAA trained individuals will have the right to review your information or send communication to you based on your authorized signature below.

PLEASE COMPLETE

By enrolling in the Live Better! Wellness Club™ you will receive discounts storewide and be eligible for the Live Better! Generic Prescription Program.

☐ **ENROLLED**

☐ **Live Better! Wellness Club™ = $9.99**

Name (as it appears on shoppers card) _____ _____

LAST **FIRST** **MI**

Street Address _____

City _____ **State**_____ **Zip** _____

Date of Birth_____/ _____/ _____ **Gender ☐ Male ☐ Female**

Home Phone (_____) _____-_____ **Cell Phone:** (_____) _____-_____

E-Mail Address: _____

LIVE BETTER! GENERIC PRESCRIPTION PROGRAM

☐ **By checking this box, you agree to become a member of our Live Better! Generic Prescription Program. You also verify that you are (a) uninsured or (b) otherwise not utilizing prescription drug benefits for the generic drugs included in the program. A list of the included generic drugs is available at the Pharmacy.**

***A separate [PH04] Confidential Patient Profile form must be completed for each additional Family member.**

LIVE BETTER! WELLNESS CLUB ™

Would you like to receive up-to-date educational information and store specials about your interests and health concerns?	Yes _____ No _____
Would you like to receive healthy recipes?	Yes _____ No _____
Are you interested in participating in a nutritional supermarket tour?	Yes _____ No _____
How would you prefer to receive written information?	Mail ____ E-mail ____

***NUTRITIONAL INTERESTS* (please check all that apply):**

☐ Fat Free or Low Fat Foods
☐ Food Allergy (specify)_____
☐ Gluten Free Foods
☐ Gluten Free (no cross contamination)
☐ Lactose Intolerance
☐ Low Carbohydrate Foods
☐ Low cholesterol foods
☐ High Fiber Foods
☐ Reduced Sugar Foods
☐ Reduced Sodium or Low Sodium Foods
☐ Nut Free Foods

A&P Pathmark superfresh The Food Emporium waldbaums

***HEALTH ISSUES THAT ARE OF INTEREST TO YOU*. Please check all that apply.**

☐Acne	☐Eczema/Psoriasis	☐Mouth/Throat Problems, Long Term
☐Alcohol Dependence	☐Endometriosis	☐Muscular/Neuromuscular Problems
☐Allergy	☐Epilepsy / Seizures	☐Obesity
☐Anemia	☐Erectile Dysfunction (ED)	☐Osteopenia
☐Angina	☐Eye problems	☐Osteoporosis
☐Anxiety	☐Fibroid Cysts	☐Parkinson's Disease
☐Arthritis	☐Gallbladder Disease	☐Peripheral Vascular Disease (PVD)
☐Asthma	☐Gastrointestinal Problem	☐Pregnancy
☐Atherosclerosis	☐Glaucoma	☐Prostate condition, BPH
☐Back Pain	☐Gout	☐Psychoses
☐Blood Clotting Disorders	☐HIV Infection	☐Pulmonary Diseases / COPD
☐Blood Dyscrasias	☐Heart Arrhythmias	☐Rheumatoid Arthritis
☐Blood Pressure, High	☐Heart Disease	☐Shingles Sleep Disorders
☐Blood Pressure, Low	☐Heart Failure, Congestive	☐Sleep Disorders
☐Breast Feeding	☐High Cholesterol	☐Stroke
☐Cancer	☐Hypoglycemia	☐Thyroid, Overactive
☐Celiac Disease	☐Irritable Bowel Syndrome	☐Thyroid, Underactive
☐Cold Sores	☐Kidney Disorders	☐Ulcerative Colitis Ulcers
☐Dementia	☐Liver Disorders	☐Ulcers
☐Depression	☐Lupus Erythematosus	☐Upper Respiratory Problems
☐Depression, Manic	☐Macular degeneration	☐Urinary Tract Infection
☐Dermatologic Disorders	☐Menopause	☐Weight Over
☐Diabetes, Type 1	☐Migraine Headache	☐Weight Under
☐Diabetes, Type 2	☐Mitral Valve Disease	☐Ear Infection, Long Term
☐Other(please specify):_____		

PAIN RELIEVERS, VITAMINS OR HERBAL SUPPLEMENTS THAT ARE OF INTEREST TO YOU		
☐ ACETAMINOPHEN (i.e., TYLENOL®)	☐ GINKGO BILOBA	☐ NAPROXEN (i.e., ALEVE®)
☐ ASPIRIN (i.e., BAYER®)	☐ GINSENG	☐ ST. JOHN'S WORT
☐ CALCIUM	☐ IBUPROFEN (i.e., ADVIL®)	☐ VITAMIN B
☐ ECHINACEA	☐ IRON SUPPLEMENT	☐ VITAMIN C
☐ GARLIC	☐ MULTI-VITAMIN	☐ VITAMIN E
☐ OTHER (Please Specify)		

Please check all that apply (optional):

☐ I have cat(s)	☐ I have dog(s)	☐ I am a smoker	☐ I have sensitive teeth
☐ I have dentures	☐ I have a newborn 0-12 mos.	☐ I have a toddler 1-5yrs. old	

Member Signature (all members must sign):_____ **Date:**_____

Member Name (Please Print): _____ **Type of ID given:** _____

If under 18 years old. _____ _____
Personal Representative's Name **Relationship to Customer**

I understand that I may revoke this Authorization in writing at any time by sending a letter to The Great Atlantic & Pacific Tea Company 2 Paragon Drive Montvale, NJ 07645 Attn: Sr. Director of Pharmacy, except to the extent that the Pharmacy has taken action in reliance on its authorization. The enrollment fee is non-refundable. **This Authorization ends on December 31, 2009 unless otherwise designated.**

I authorize (Personal Representative's Name) _____, (Relationship to Customer) _____, to use my bonus card and receive information on my behalf.

Family Member Signature:_____ **Date:**_____

Pharmacy Employee Who Entered Information (Full Name) _____ Date _____