Hannaford Rx healthy saver® plus

SCRIPTSAVE®

Please complete **ONE** enrollment form for **EACH SUBSCRIBER. PLEASE PRINT CLEARLY.** Incomplete forms cannot be processed. The subscriber section of the enrollment form must be completed each time a form is submitted.

Subscriber Information:

First Name	MI	Last Name	Person Code	Date of Birth (MM/DD/YYYY)
			01	

Mailing Address	City	State	Zip-Code

Phone Number	Email Address	Allergies

Customer Status

❑ I am an **EXISTING** Hannaford Pharmacy customer ❑ I am a **NEW** Hannaford Pharmacy customer

Enrollment Information for Dependents Covered in Addition to Subscriber:

First Name	MI	Last Name	Person Code	Relationship	Date of Birth (MM/DD/YYYY)
			02		
Allergies					
First Name	MI	Last Name	Person Code	Relationship	Date of Birth (MM/DD/YYYY)
			03		
Allergies					
First Name	MI	Last Name	Person Code	Relationship	Date of Birth (MM/DD/YYYY)
			04		
Allergies					

HIPAA Authorization.

Terms. This prescription drug savings program [Hannaford healthy saver plus] is administered by Medical Security Card Company (MSC) of Tucson, Arizona. In administering the Hannaford healthy saver plus program, MSC receives individually identifiable health information (including but not limited to the information provided on this enrollment form) from Hannaford Pharmacies, the pharmacies processing the Hannaford healthy saver plus program transactions or directly from you. Your authorization is required as a condition of enrollment in the Hannaford healthy saver plus program as MSC must have this information to administer its point-of-sale discount prescription service. The individually identifiable health information provided to MSC and Hannaford Pharmacy is not transferred, sold or otherwise disclosed to third parties, except as necessary for the proper administration of the Hannaford healthy saver plus program or as may be otherwise required by law, and is always protected as Confidential Private Information. If your medical information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives your medical information and this re-disclosure may not be protected by the applicable privacy laws. For additional information, including the Hannaford Pharmacy privacy policy, please visit: http://www.hannaford.com/Contents/Common/PrivacyStatement.shtml.

Authorization. I understand that my signature on this enrollment form constitutes my written authorization for MSC to receive and use the individually identifiable health information described above for the proper administration of the Hannaford healthy saver plus program in accordance with applicable law. This authorization shall remain in effect for the duration of my enrollment in the Hannaford healthy saver plus program. I have the right to revoke this authorization through written communication at any time (Medical Security Card Company, 4911 E. Broadway, Suite 200, Tucson, AZ 85711), except to the extent that my medical information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of this program, my revocation of this authorization shall result in cancellation of my enrollment in the Hannaford healthy saver plus program.

If you are signing on behalf of dependent family members, your signature verifies that you are the parent/legal guardian or the authorized representative of the individuals identified above.

Authorization Signature: _____ Date: _____

Additional Health Savings Information. Pursuant to your enrollment in the Hannaford healthy saver plus program, MSC and Hannaford Pharmacy may also provide you with special information to enhance your health, such as drug price comparisons, and/or special savings opportunities (Additional Health Savings Information) through programs administered by MSC and/or Hannaford Pharmacy. Your signature below constitutes your written authorization for MSC and Hannaford Pharmacy to provide you with Additional Health Savings Information as described above. You may opt out of receiving future transmissions of Additional Health Savings Information by contacting 1-866-315-6421.

Authorization Signature: _____ Date: _____

Right to Receive Copy of This Authorization. I understand that I have a right to receive a copy of this signed authorization upon request.

FORM MUST BE COMPLETED AND RETURNED TO A HANNAFORD PHARMACY ASSOCIATE