AlliancePharmacy GROUP

* denotes mandatory sections

Attention: Customer Service Department

ACCOUNT ACTIVATION FORM

*PERSONAL INFORMATION

FIRST NAME: _____ SURNAME: _____

GENDER: ☐ M ☐ F DATE OF BIRTH: _____ PROV. HEALTH CARD: _____

HOME ADDRESS: _____ APT/SUITE: _____

CITY: _____ PROVINCE: _____ P. CODE: _____ DELIVERY CARE OF NAME: _____

TELEPHONE : HOME: _____ WORK: _____ MOBILE: _____

Name of Group, Organization or Employer: _____

PLEASE LIST ANY ALLERGIES (eg. pencillin, food etc.): _____

PLEASE LIST ALL CURRENT MEDICATIONS (Prescription, Herbal, Over-The-Counter etc.): _____

_____

_____

! INFORMATION DISCLOSURE

Your prescription information is confidential. I authorize _____ as my agent who is entitled to act for me in my stead in all areas that relate to prescription services from Alliance Pharmacy Group Inc. In addition, for telephone verification please provide a security code or keyword that can by requested by an APG representative to authenticate authorization.

Your Signature _____ Security Code/KeyWord: _____

eg. Mother's Maiden Name, Your 1st pet's name, numeric code

FOR YOUR CONVENIENCE... WOULD YOU LIKE

REFILL REMINDERS? YES NO

A TEXT MESSAGE VERIFYING RECEIPT OF YOUR PRESCRIPTION AND NOTIFICATION OF DELIVERY ADDRESS? YES NO

A FEDEX SHIPPING EMAIL NOTIFICATION TO TRACK YOUR PRESCRIPTION? YES NO EMAIL: _____

APG TO COORDINATE TRANSFER OF YOUR PRESCRIPTION FROM YOUR EXISTING PHARMACY? YES NO Pharmacy Tel #: _____

*DELIVERY OPTIONS (must be available between 9am - 5pm to sign for package)

☐ SAME AS HOME

PLACE OF WORK NAME: _____

DELIVERY ADDRESS: _____ APT/SUITE: _____

CITY: _____ PROVINCE: _____ POSTAL: _____ DELIVERY CARE OF NAME: _____

INSURANCE INFORMATION ☐ I'm not sure how to complete this section, please call me.

INSURANCE COMPANY/PHARMACY BENEFIT MANAGEMENT: _____

ID#/CERTIFICATE#: _____ GROUP#/PLAN#: _____

CARRIER ID# _____ ADDITIONAL NUMBERS ON CARD: _____

PAYMENT METHODS ☐ Please call me for my payment information

CARDHOLDER NAME: _____ ☐VISA ☐MASTERCARD

CREDIT CARD #: _____ EXP DATE: _____

PLEASE **FAX** TO CUSTOMER SERVICE DEPARTMENT: **1-877-835-8329** OR MAIL TO: 20 Eurbacher Lane - Unit 2 Aurora, ON L4G 6W1