

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 three-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.



This can help you save gas and time.

No trips to the pharmacy!

No waiting in line!

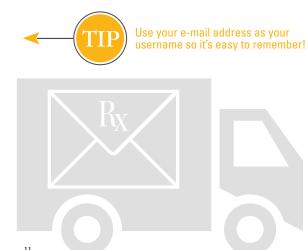
- You can easily refill your medication online or by phone.
- We can transfer any existing prescriptions for you.

Before you can sign up for Prescription Delivery Service, you must register on myWDRX.com. If you haven't already done this, here's how:

- **1** Go to www.myWDRX.com. Click on "New Member? Start Here."
- Complete the registration form.
- Create a username and password.
- Accept the Terms of Use.
- Click "Register Now."

Get Started!

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







Signature _

Prescription Delivery Service Enrollment Form

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

| lling Address | t Name First | | | | Middle Int | Date of Birth |
|---|---|--|---|--|---|--|
| illing Address | | | | | State | Zip Code |
| shipping Address (☐ Same as Billing Address) | | | | | State | Zip Code |
| lome Phone Cell Phone | | | Il Address (to receive information | about your prescription orders) | | |
| ontact Preference (select one): | ☐ Email ☐ Automa | ated Phone Message | | | | |
| Group Name (Primary) | | | Group Name (Secondary) | | | |
| roup ID# | # | Group ID# | Member ID# | | | |
| | 4 | ALLERGIES AND H | EALTH CONDITION | ONS | | |
| or your safety, WellDyneRx requi n a separate piece of paper. | ires allergy and health cond | ition information for you and your | dependents before dispensing | g medication. Please enclose add | ditional fami | ily member info |
| Cardholder Information | | Dependent Information | | Dependent Information | | |
| First & Last Name | | First & Last Name | | First & Last Name | | |
| | | | | | | |
| | | Relationship to Cardholder | | Relationship to Cardholder | | |
| | O Male O Female | Date of Birth | O Male O Female | Date of Birth | O Mal | |
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| O Amoxicillin O Aspirin O Cephalosporins | O Bleeding Disorder O COPD | O Aspirin O Cephalosporins | O Bleeding Disorder O COPD | O Aspirin O Cephalosporins | O Ble | eding Disorder |
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