

LibertyCareRx Discount Drug Card Benefit Program Lifetime Membership Enrollment Form

Section 1: Applicant Information

I am eligible to participate.

I would like to receive information about other healthcare related offers.

Name _____

Address _____

E-mail Address _____

Home Phone _____

Work Phone _____

Section 2: Plan Options

Please select one of the following plan options:

Single \$20 Family \$32

Pre-Printed Enrollment Card Number (if applicable): _____

Promo Code (if applicable): _____

Section 3: Dependents (Family coverage only)

Please identify all members of your family that reside at your address that you want included in your plan.

Last	First	MI	Relationship	Birthday			Sex M/F
				MTH	DAY	YR	
Member			SELF				
Dependent							
Dependent							
Dependent							
Dependent							

Section 4: Payment Information

Check or money order \$ _____

Credit Card

Visa

MasterCard

Card Number _____

Expiration Date _____

Name as it Appears on Card _____

Fax or mail your completed application to:

LibertyCareRx
 6400 Sheridan Drive, Suite 206
 Williamsville, NY 14221
 Fax: 1-716-204-3394
 Questions?
 Phone: 1-716-204-9059