

ENROLLMENT FORM

ELIGIBILITY

Please read the following list of eligibility requirements. If you meet all requirements, check Yes below to continue. If you have questions please contact us at 1-888-273-9734.

1. I am a legal resident of the US.
2. My current prescription insurance, if any, does not cover Enemeez.
3. I have Medicaid however my State will not cover Enemeez at this time.
4. I have household income equal to or less than:

- \$23,500 for a single person
- \$31,500 for a family of two
- \$39,500 for a family of three
- \$47,500 for a family of four
- \$55,500 for a family of five

Yes, I meet the eligibility requirements listed above.

YOUR INFORMATION

<input type="text"/> First Name	<input type="text"/> M.I.	<input type="text"/> Last Name
<input type="text"/> Address		
<input type="text"/> City	<input type="text"/> State	<input type="text"/> Zip Code
<input type="text"/> - <input type="text"/> - <input type="text"/> Telephone		<input type="text"/> / <input type="text"/> / <input type="text"/> Date Of Birth (mm/dd/yyyy)
<input type="text"/> - <input type="text"/> - <input type="text"/> Social Security Number	Did you file a tax return for the most recent tax year? <input type="checkbox"/> Yes <input type="checkbox"/> No**	
<input type="text"/> Annual Household Income	<input type="text"/> Number in household (including yourself and your spouse if married)	
MAY WE CONTACT YOU? By checking YES, you agree that Alliance Labs may contact you about new programs and services, additional products and health information or for market research purposes.		<input type="checkbox"/> Yes <input type="checkbox"/> No

PRESCRIPTION INSURANCE INFORMATION

<input type="text"/> Primary Prescription Coverage	<input type="text"/> Policy Number	
<input type="text"/> Plan Name	<input type="text"/> Primary Policy Holder Name	<input type="text"/> Insurance Co Phone

Government Insurance

Are you covered by <input type="checkbox"/> Medicare?* <input type="checkbox"/> Medicaid?*	Are you a U.S. Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
*If covered by Medicare or Medicaid you must submit a copy of your Card with this application	Are you covered by VA Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No

PROGRAM INFORMATION

ENROLLMENT

I understand that the Alliance Labs will review my enrollment form, determine my eligibility, and notify me based on the information I provide. The Administrator may at any time require additional information to determine or confirm my eligibility. If I am eligible, I will receive notification by phone or mail.

LIMITATIONS

Savings under the Program do not apply to products reimbursed under any federal or state program, including Medicaid or any private insurance, HMO, Medigap, employer, or other third-party arrangement ("Private Insurance"). By signing the enrollment form I certify that if I have any Prescription Drug Coverage, I have contacted them to cover this drug and have been turned down.

This Program is valid only to Legal U.S residents. The Program may be terminated or modified at any time.

Alliance Labs reserves the right to revise, or revoke this program at any time. If any such revision or revocation occurs, the applicant will be notified either by phone or mail.

All orders under this program will be Prepaid by the applicant via Credit Card.

Quantity restrictions do apply. Each approved participant in this program will not be allowed more than one 30 day supply per calendar month.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

I understand that Alliance Labs and the Administrator of the Program will receive information about me. I authorize Alliance Labs to:

- use that information to administer the Program and to communicate with me.
- **if you checked "no" to filing a tax return, you authorize Alliance Labs to contact the IRS for verification.

Alliance Labs does not provide/sell personal information to third party companies.

I may revoke this authorization by ending my participation in the Program by writing to Alliance Labs at 2515 E Rose Garden Lane Suite 1, Phoenix AZ 85050. Or by phone at 1-888-273-9734.

REQUIRED DOCUMENTS: (MUST BE RETURNED WITH THIS APPLICATION)

1. You must include a copy of your MEDICAID and/or MEDICARE ID cards if you have coverage with either plan.

2. YOU MUST INCLUDE PROOF OF INCOME DOCUMENTS

Acceptable Proof of Income documents include the following:

- Federal Income Tax Form (1040, 1040A, or 1040EZ, 1040X, 1722, 8453, 8879, 1099INT)
- Yearly Benefits Statement (SSA1099 or 4506T)
- IRS Telefile Worksheet
- W2 Tax Statement
- Social Security, Pension, or Railroad Retirement Statements (SSA-1099, 4506T)
- Statements of interest, dividends, or other income (1099-INT, 1099, 1099T, 1099-DIV)

IMPORTANT: By Signing below, I certify that I have read and understand the program information on this form. Additionally, I certify that the information on this enrollment form, including all copies of income documentation, is accurate and complete and that I am authorized to sign this application. I understand and agree that an Administrator of this program may contact me in the future to verify this information.

Applicant	
<input type="text"/>	<input type="text"/>
Print Name	Date
<input type="text"/>	
Signature	

Alliance Labs (internal company use only)	
<input type="text"/>	<input type="text"/>
Reviewed By	Date
<input type="text"/>	
Approval Level	