

Introduction:

HCGITMeds is a voluntary prescription drug program that is available to eligible Employees, Retirees and their Dependents of Hampshire County Group Insurance Trust, MA. For your convenience, a list of eligible medications is located on the back of this page.

Copayments:

All member copayments have been waived for this program only.

HCGITMeds		Vs.	Current local purchase plan			
Annual Cost No Copays!			Monthly Copays		Refills	Annual Savings
\$0	vs.		\$25 (Tier 2)	x	12	= \$300 / Script
\$0	vs.		\$45 (Tier 3)	x	12	= \$540 / Script

Ordering Instructions:

To place your first order simply complete the enrollment form and include a new prescription for each medication. Please allow 4 weeks for delivery.

Ask your doctor for a prescription for a **3 month supply** with **3 refills**. We will call you prior to each renewal to ensure that you have a continuous supply.

Medications must be tried for 30 days before ordering through **HCGITMeds**.

RETURN YOUR COMPLETED AND SIGNED ENROLLMENT FORM AND ORIGINAL PRESCRIPTIONS:



BY FAXING TO: 1-866-715-MEDS (6337) TOLL FREE

Faxed prescriptions are ONLY accepted if sent directly from the physician's office.

OR



BY MAILING TO: HCGITMeds

P.O. Box 44650

Detroit, MI 48244-0650

More forms are available:

Additional forms may be obtained by printing them from the website at www.HCGITMeds.com or by contacting our Customer Service Representatives toll free at **1-866-893-(MEDS) 6337**.

WELCOME TO HCGITMEDS

ABILIFY 2MG	CYMBALTA 60MG	INVIRASE 500MG	PROTOPIC OINTMENT 0.1%	VOSPIRE ER 4MG
ABILIFY 5MG	DETROL (G) 1MG	JALYN 0.5MG/0.4MG	QVAR 40MCG 50MCG	VYTORIN 10/10MG
ABILIFY 10MG	DETROL (G) 2MG	JANUMET 50/500	QVAR 80MCG 100MCG	VYTORIN 10/20MG
ABILIFY 15MG	DETROL LA 2MG	JANUMET 50/1000	RANEXA 500MG	VYTORIN 10/40MG
ABILIFY 20MG	DETROL LA 4MG	JANUVIA 25MG	RAPAMUNE 1MG	VYTORIN 10/80MG
ABILIFY 30MG	DEXILANT DR 30MG	JANUVIA 50MG	RELPAZ 20MG	WELLBUTRIN XL (G) 150MG
ABILIFY DISCMELT 10MG	DEXILANT DR 60MG	JANUVIA 100MG	RELPAZ 40MG	WELLBUTRIN XL (G) 300MG
ABILIFY DISCMELT 15MG	DIFFERIN CREAM (G) 0.1%	JENTADUETO 2.5MG/850MG	RENAGEL 800MG	XARELTO 10MG
ABILIFY SOLUTION 1MG/ML	DIFFERIN GEL 0.3%	JENTADUETO 2.5MG/1000MG	REVELA 800MG	XARELTO 15MG
ACIPHEX 20MG	DIFFERIN GEL (G) 0.1%	LAMICTAL DISPERSIBLE 25MG	RETIN A CREAM (G) 0.05%	XARELTO 20MG
ACTONEL 5MG	DIOVAN 40MG	LATUDA 40MG	RETIN A MICRO GEL 0.04%	XELODA 150MG
ACTONEL 30MG	DIOVAN 80MG	LATUDA 80MG	RETIN A MICRO GEL (G) 0.1%	XELODA 500MG
ACTONEL 35MG	DIOVAN 160MG	LATUDA 120MG	RETIN-A MICRO GEL 0.1% PUMP	YAZ (G) 3-0.02MG
ACTONEL 150MG	DIOVAN 320MG	LESCOL 20MG	REVATIO 20MG	ZEMPLAR 1MCG
ACULAR LS SOLUTION (G) 0.4%	DIOVAN HCT (G) 80/12.5MG	LESCOL 40MG	RHEUMATREX 2.5MG	ZERIT 40MG
ACULAR OPHTH DROPS (G) 0.5%	DIOVAN HCT (G) 160/12.5MG	LESCOL XL 80MG	RHINOCORT AQ 32MCG	ZETIA 10MG
ADCIRCA 20MG	DIOVAN HCT (G) 160/25MG	LEUKERAN 2MG	RHINOCORT AQ 64MCG	ZIAGEN 300MG
ADVAIR DISKUS 100MCG	DIOVAN HCT (G) 320/12.5MG	LEXIVA 700MG	RIDAURA 3MG	ZOMIG 2.5MG
ADVAIR DISKUS 250MCG	DIOVAN HCT (G) 320/25MG	LIPITOR (G) 10MG	RILUTEK 50MG	ZOMIG NASAL SPRAY 5MG
ADVAIR DISKUS 500MCG	DIOVAN HCT (G) 320/25MG	LIPITOR (G) 20MG	SANCTURA (G) 20MG	ZOMIG ZMT 2.5MG (1X6)
ADVAIR HFA 45/21MCG	DOVONEX CREAM 50MCG	LIPITOR (G) 40MG	SANCTURA XR 60MG	ZOVIRAX CREAM 5%
ADVAIR HFA 115/21MCG	DOVONEX SOLUTION (G) 50MCG/ML	LIPITOR (G) 80MG	SAPHRIS 5MG	ZYCLARA 3.75%
ADVAIR HFA 230/21MCG	DULERA 100MCG/5MCG	LOCOID LIPOCREAM 0.1%	SAPHRIS 10MG	ZYTIGA 250MG
ADVAIR HFA 230/21MCG	DULERA 200MCG/5MCG	LOCOID OINTMENT 0.1%	SEREVENT DISKUS 50MCG	
AGGRENOX 200/25MG	EDARBI 40MG	LOTEMAX 0.5%	SEROQUEL XR 50MG	
ALDARA CREAM (G) 5%-250MG	EDECIN 25MG	LOTRISONE CREAM (G)	SEROQUEL XR 150MG	
ALKERAN 2MG	EFFIENT 5MG	LUMIGAN OPHTH 0.01%	SEROQUEL XR 200MG	
ALPHAGAN-P OPHTH SOLUTION (G) 0.15%	EFFIENT 10MG	MAXALT (G) 5MG	SEROQUEL XR 300MG	
ALREX 0.2%	ELIDEL 1%	MAXALT (G) 10MG	SEROQUEL XR 400MG	
ALVESCO 80MCG 100MCG	ELIQUIS 5MG	MAXALT MELT (G) 10MG	SOLARAZE GEL 3%	
ALVESCO 160MCG 200MCG	ELMIRON 100MG	MESTINON TS 180MG	SORIATANE 10MG	
ARAVA (G) 10MG	EMTRIVA 200MG	METRO CREAM (G) 0.75%	SORIATANE 25MG	
ARAVA (G) 20MG	ENABLEX 7.5MG	MICARDIS 20MG	SPIRIVA 18MCG	
ARTHROTEC 50MG	ENABLEX 15MG	MICARDIS 40MG	STRATTERA 40MG	
ARTHROTEC 75MG	ENTOCORT (G) 3MG	MICARDIS 80MG	STRATTERA 60MG	
ASACOL HD 800MG	EPIPEN 0.3MG	MICARDIS HCT 40/12.5MG	STRATTERA 80MG	
ASMANEX TWISTHALER 220MCG	EPIPEN JR 0.15MG	MICARDIS HCT 80/12.5MG	STRATTERA 100MG	
ASTELIN (G) 137MCG	EPIVIR 150MG	MICARDIS HCT 80/25MG	SURMONTIL 25MG	
ATACAND 4MG	EPIVIR/HBV 100MG	MIGRANAL NASAL SPRAY 4MG/ML	TARCEVA 100MG	
ATACAND 8MG	EPZICOM	MIRAPEX ER 0.375MG	TARCA 2/180MG	
ATACAND 16MG	ESTROGEL GEL 0.06%	MIRAPEX ER 0.75MG	TARCA 2/240MG	
ATACAND 32MG	EVISta 60MG	MIRAPEX ER 1.5MG	TARCA 4/240MG	
ATRIPLA 600-200-300MG	EXELON 3MG	MIRAPEX ER 2.25MG	TASIGNA 150MG	
ATROVENT HFA 20UG	EXELON 6MG	MIRAPEX ER 3MG	TASIGNA 200MG	
AVANDIA 8MG	EXELON 4.6 MG/24HR	MIRAPEX ER 3.75MG	TASMAR 100MG	
AVODART 0.5MG	EXELON 9.5MG/24HR	MIRAPEX ER 4.5MG	TAZORAC CREAM 0.05%	
AXERT 6.25MG	EXFORGE 5/160MG	MIRAPEX ER 4.5MG	TAZORAC CREAM 0.1%	
AXERT 12.5MG	EXFORGE 10/160MG	MULTAQ 400MG	TAZORAC GEL 0.05%	
AZILECT 1MG	EXFORGE 320/5MG	MYRBETRIQ 25MG	TAZORAC GEL 0.1%	
AZOPT OPHTH DROPS 1%	EXFORGE 320/10MG	MYRBETRIQ 50MG	TEKTRUNA HCT 300/25MG	
AZOR 20/5MG	EXFORGE HCT 160/12.5/5	NAMENDA 5MG	TEKTRUNA HCT 300-12.5	
AZOR 40/5MG	EXFORGE HCT 160/12.5/10	NASACORT AQ (G) 55MCG	TEMOVATE OINTMENT (G) 0.05%	
AZOR 40/10MG	EXFORGE HCT 160/25/5	NASONEX 50MCG	TEVETEN HCT 600/12.5MG	
BACTROBAN CREAM 2%	EXFORGE HCT 320/25/10	NEXIUM 20MG	TOBEX 0.3%	
BANZEL 200MG	EXJADE 125MG	NEXIUM DR 10MG	TOBEX OINTMENT 0.3%	
BANZEL 400MG	EXJADE 250MG	NIASPAN 500MG	TOPICORT CREAM (G) 0.25%	
BARACLUDE 0.5MG	EXJADE 500MG	NIASPAN 750MG	TOVIAZ 4MG	
BECONASE AQ 0.04%	FARESTON 60MG	NIASPAN 1000MG	TOVIAZ 8MG	
BENICAR 20MG	FELDENE 10MG	NILANDRON 150MG	TRACLEER 62.5MG	
BENICAR 40MG	FELDENE 20MG	NORITATE CREAM 1%	TRACLEER 125MG	
BENICAR HCT 20MG/12.5MG	FINACEA 15%	NORVIR 100MG	TRADJENTA 5MG	
BENICAR HCT 40MG/12.5MG	FLOMAX (G) 0.4MG	OMNARIS NASAL SPRAY 50MCG	TRAVATAN Z OPHTH SOLUTION 0.004%	
BENICAR HCT 40MG/25MG	FLOMASE (G) 50MCG	ONGLYZA 2.5MG	TRIBENZOR 20/5/12.5MG	
BENZACLIN PUMP	FLOVENT 44MCG 50MCG	ONGLYZA 5MG	TRIBENZOR 40/5/12.5MG	
BETIMOL 0.5%	FLOVENT 110MCG 125MCG	ORTHO-EVRA	TRIBENZOR 40/5/25MG	
BETOPTIC S OPHTH 0.25%	FLOVENT 220MCG 250MCG	ORTHO-TRI-CYCLEN LO	TRIBENZOR 40/10/12.5MG	
BONIVA (G) 150MG	FLOVENT DISKUS 50MCG	PENTASA 500MG	TRIBENZOR 40/10/25MG	
CARDURA XL 4MG	FLOVENT DISKUS 100MCG	PLAVIX (G) 75MG	TRUVADA 200-300MG	
CEENU 40MG	FLOVENT DISKUS 250MCG	PRADAXA 75MG	TWYNSTA 40/5MG	
CELEBREX 100MG	FORADIL + AEROLIZER 12MCG	PRADAXA 150MG	TWYNSTA 40/10MG	
CELEBREX 200MG	FOSAMAX-D 70/2800MG	PRANDIN 0.5MG	TWYNSTA 40/10MG	
CLIMARA PRO 0.045/0.015	FOSRENOL CHEW 250MG	PRANDIN 1MG	TWYNSTA 80/5MG	
COMPLERA 200/25/300MG	FOSRENOL CHEW 500MG	PRANDIN 2MG	TWYNSTA 80/10MG	
COSOPT OPHTH DROPS (G) 2%/0.5%	FOSRENOL CHEW 1000MG	PREMARIN 0.3MG	ULORIC 80MG	
COVERA-HS 240MG	FROVA 2.5MG	PREMARIN 0.625MG	VAGIFEM 10MCG	
CRESTOR 5MG	GELNIQUE 10%	PREMARIN 1.25MG	VALCYTE 450 MG	
CRESTOR 10MG	GILENYA 0.5MG	PREMPRO 0.3/1.5MG	VERAMYST 27.5MCG	
CRESTOR 20MG	GLEEVEC 100MG	PREMPRO 0.625MG/2.5MG	VESICARE 5MG	
CRESTOR 40MG	GLEEVEC 400MG	PREMPRO 0.625MG/5MG	VESICARE 10MG	
CUPRIMINE 250MG	GLUCAGEN HYPOKIT 1MG	PREVACID SOLUTAB 15MG	VIRAMUNE 200MG	
CUTIVATE CREAM 0.05%	HEPSERA 10MG	PREVACID SOLUTAB 30MG	VIRAMUNE XR 400MG	
CUTIVATE OINTMENT 0.005%	INCIVEK 375MG	PREZISTA 800MG	VIVELLE-DOT 25MCG	
CYMBALTA 20MG	INLYTA 1MG	PRISTIQ 50MG	VIVELLE-DOT 37.5MCG	
CYMBALTA 30MG	INVEGA 3MG	PRISTIQ 100MG	VIVELLE-DOT 50MCG	
	INVEGA 6MG	PROSCAR (G) 5MG	VIVELLE-DOT 75MCG	
	INVEGA 9MG	PROTOPIC OINTMENT 0.03%	VIVELLE-DOT 100MCG	

NOTE: Medication names appearing with (G) are available in a Generic version from your local or U.S. mail order pharmacy. For a greater savings to your healthcare plan, ask your physician about taking a Generic equivalent of your medication.



MEMBER ID #:

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION (S) TOLL-FREE TO: 1-866-715-(MEDS) 6337
OR
MAIL TO: HCGITMeds, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

PATIENT INFORMATION: Birthdate _____
DD/MM/YYYY

Phone (Home) _____ Phone (Work or Cell) _____

First Name (please print) _____ Initial _____ Last Name _____

Street Address _____

City/State _____ Zip Code _____

NOTE:
Please request a **3-month** supply of medication with **3 refills**.

New-to-you medications must be domestically prescribed, filled and taken for a period of no less than 30 days.

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. <i>Ex. Crestor (This is NOT a prescription.)</i>	Strength <i>Ex. 10 mg</i>	Reason for Taking <i>Ex. Cholesterol</i>	Daily Use <i>Ex. Once Daily</i>

MEDICAL HISTORY (If you require more space, please attach a separate piece of paper.) Male Female

(i) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. _____

(ii) Hospitalizations: (stays in hospital during the past 5 years) _____

(iii) Present illness: (ongoing) e.g., Diabetes, Heart disease, Osteoporosis, etc. _____

(iv) Drug allergies: NO YES If yes, please specify: _____

AUTHORIZATION

I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse and that the information provided by me is accurate and true.

I request and authorize Hampshire County Group Insurance Trust, MA as my appointed agent, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service as determined appropriate by Hampshire County Group Insurance Trust, MA in the administration of my employment benefits.

Subscriber Signature:

Date: (DD/MM/YY)

CONFIRMATION AND REPRESENTATIONS

I, the undersigned, am entering into this agreement with *CanaRx Group Inc. ("CanaRx")* in order that I may obtain access to medically necessary prescription drugs at low costs.

1. I am of the age of majority in the jurisdiction in which I ordinarily reside;
2. I am not restricted from making my own medical decisions under the laws of the jurisdiction in which I ordinarily reside;
3. The medications that I have requested that CanaRx facilitate my obtaining were prescribed by a duly qualified and licensed medical practitioner in the United States;
4. I have not violated any laws in the jurisdiction in which I ordinarily reside, in obtaining the prescription for the ordered product;
5. This prescription has not been altered in any way nor has it been filled previously. I agree to mail or fax from my doctor's office the original copy of the prescription to CanaRx;
6. I am under the ongoing care of a physician in my residing jurisdiction (my "U.S. physician"), and therefore, I am not seeking or relying on any medical information from CanaRx or any CanaRx contracted physician;
7. My prescription will not be used in any way whatsoever except as prescribed by my medical practitioner who originally issued the prescription;
8. I will not permit anyone else to use the prescription or any medications which I receive;
9. I will use any medications obtained for me by CanaRx strictly in accordance with the instructions provided by the physician who prescribed the medications; and
10. In the event that I suffer any side effects from any medications I receive through the services of CanaRx, I will immediately contact my U.S. physician.
11. I certify that I am a resident of the United States and not a resident of any other country.

AUTHORIZATION AND CONSENT

I further provide my authorization and consent to the following:

1. I hereby appoint CanaRx and its delegates or contractors as my paid agent and attorney for the purposes of obtaining prescriptions which correspond to the prescriptions provided by my U.S. physician.
2. I authorize CanaRx and its delegates or contractors to arrange the purchase and delivery of the medications prescribed to me on the terms outlined in this agreement and to the same extent as if I personally took such steps.
3. I consent and authorize CanaRx to collect my personal medical information and to maintain on file the information necessary to verify and process future orders, including but not limited to my full name, address, phone number, complete medical history and payment information.
4. I authorize my U.S. physician and CanaRx to release any and all information required in connection with my physical condition, including but not limited to all X-rays, medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions and/or any other knowledge or information which they may possess to a CanaRx contracted physician who may be required to review my health record for the purposes of being in a position to evaluate the medical necessity and indications for prescription medication.
5. I authorize the CanaRx contracted physician to contact my U.S. physician to discuss my prescription if necessary.
6. I further authorize the CanaRx contracted physician to issue prescriptions for medications I have ordered only if he/she deems it advisable and appropriate.
7. I further authorize the CanaRx contracted physician to release any and all information that may be required by any CanaRx contracted pharmacy for the purpose of having my prescriptions filled.
8. I further authorize CanaRx to make payments on my behalf to the CanaRx contracted pharmacy for the filling of my prescriptions and to the CanaRx contracted physician for services rendered on my behalf.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments and releases to *CanaRx*, including all of its employees, its contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. I acknowledge that my U.S. physician is my primary physician and the CanaRx contacted physician is being asked only to review the information contained in the Personal Medical History for the purpose of authorizing any properly prescribed medications for fulfillment from a CanaRx contracted pharmacy.
2. I acknowledge that CanaRx has made no representations or warranties to me, including, without limitation, representations or warranties regarding the use of fitness for any particular purpose of the medications delivered (including, without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease, or its potential or actual side or adverse effects whether previously known or unknown).
3. I acknowledge that I wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx to facilitate this matter. I understand and appreciate that the CanaRx contracted physician will rely on the accuracy of the examination and prescription provided by my U.S. physician.
4. I hereby specifically acknowledge that I am aware that CanaRx may transmit my personal information by electronic means (for example fax, or secure internet) to its agents, contracted physicians and pharmacies. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that CanaRx, as a custodian of my personal information, will take all appropriate precautions to protect my personal information from improper disclosure or use. I hereby consent to CanaRx's transmission of my personal information by electronic means to its agents, contracted physicians and pharmacies.
5. I release CanaRx and all of their officers and directors, agents, employees and contractors from any and all causes of action with respect to errors or omissions by the company or agency responsible for transporting my order.
6. I acknowledge that I have purchased my medications internationally for personal use and understand that my medications may be subject to U.S. border seizure. I specifically confirm, acknowledge and agree that title to my medication passes to me when my medications are shipped from the CanaRx contracted pharmacy.
7. I acknowledge that CanaRx, as my paid agent, requires payment in full prior to shipment and that my order may not be returned for a refund or an exchange.

FURTHER ACKNOWLEDGEMENT & RELEASE

I hereby make the following further acknowledgement and release the plan holder, its employees, officers, agents, heirs and assigns:

1. I acknowledge that the plan holder, has made no representations or warranties to me, including without limitation, representations or warranties regarding the use for any particular purpose the medication (s) delivered, including without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease or its potential or actual side or adverse effects whether previously known or unknown.
2. I acknowledge that child protective packaging may not be used in filling my prescription. I promise that upon my receipt of the medicine I will take all steps necessary to prevent any child from having unauthorized access to the medicine. I hereby release CanaRx Group and all its officer, directors, agents, employees, and contractors, including the pharmacy that fills my prescription, from any and all claims arising from or relating to the use of, or failure to use, child protective packaging in filling my prescription .
3. I release the plan holder its officers, employees, agents, heirs and assigns from (i) any and all causes of actions with respect to errors or omissions by the company or agency responsible for transporting my order; (ii) any and all causes of actions with respect to errors or omissions by CanaRx Group Inc. in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use of any medications delivered through this program which are utilized for any purpose whatsoever.

MEMBER ID #:

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337
OR
MAIL TO: HCGITMeds, P.O. BOX 44650, DETROIT, MI., 48244-0650 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337

PATIENT INFORMATION: Birthdate _____ SPOUSE
DD/MM/YYYY DEPENDENT

NOTE:
Please request a **3-month** supply of medication with **3 refills**.

Phone (Home) _____ Phone (Work or Cell) _____

New-to-you medications must be domestically prescribed, filled and taken for a period of no less than 30 days.

First Name (please print) Initial Last Name

Street Address

City/State Zip Code

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. <i>Ex. Crestor (This is NOT a prescription.)</i>	Strength <i>Ex. 10 mg</i>	Reason for Taking <i>Ex. Cholesterol</i>	Daily Use <i>Ex. Once Daily</i>

MEDICAL HISTORY (If you require more space, please attach a separate piece of paper.) Male Female

(i) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. _____

(ii) Hospitalizations: (stays in hospital during the past 5 years) _____

(iii) Present illness: (ongoing) e.g., Diabetes, Heart disease, Osteoporosis, etc. _____

(iv) Drug allergies: NO YES If yes, please specify: _____

AUTHORIZATION IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18

I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that he/she has been, and will be, regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse and that the information provided above is accurate and true. I request and authorize Hampshire County Group Insurance Trust, MA as my authorized agent, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Parent's/Guardian's Signature _____

Date: (DD/MM/YY)

AUTHORIZATION IF THE PATIENT IS THE SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER

I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the above listed medication for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse and that the information provided by me is accurate and true. I request and authorize Hampshire County Group Insurance Trust, MA as my authorized agent, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Patient Signature: _____

Date: (DD/MM/YY)

CONFIRMATION AND REPRESENTATIONS

I, the undersigned, am entering into this agreement with *CanaRx Group Inc. ("CanaRx")* in order that I may obtain access to medically necessary prescription drugs at low costs.

1. I am of the age of majority in the jurisdiction in which I ordinarily reside;
2. I am not restricted from making my own medical decisions under the laws of the jurisdiction in which I ordinarily reside;
3. The medications that I have requested that CanaRx facilitate my obtaining were prescribed by a duly qualified and licensed medical practitioner in the United States;
4. I have not violated any laws in the jurisdiction in which I ordinarily reside, in obtaining the prescription for the ordered product;
5. This prescription has not been altered in any way nor has it been filled previously. I agree to mail or fax from my doctor's office the original copy of the prescription to CanaRx;
6. I am under the ongoing care of a physician in my residing jurisdiction (my "U.S. physician"), and therefore, I am not seeking or relying on any medical information from CanaRx or any CanaRx contracted physician;
7. My prescription will not be used in any way whatsoever except as prescribed by my medical practitioner who originally issued the prescription;
8. I will not permit anyone else to use the prescription or any medications which I receive;
9. I will use any medications obtained for me by CanaRx strictly in accordance with the instructions provided by the physician who prescribed the medications; and
10. In the event that I suffer any side effects from any medications I receive through the services of CanaRx, I will immediately contact my U.S. physician.
11. I certify that I am a resident of the United States and not a resident of any other country.

AUTHORIZATION AND CONSENT

I further provide my authorization and consent to the following:

1. I hereby appoint CanaRx and its delegates or contractors as my paid agent and attorney for the purposes of obtaining prescriptions which correspond to the prescriptions provided by my U.S. physician.
2. I authorize CanaRx and its delegates or contractors to arrange the purchase and delivery of the medications prescribed to me on the terms outlined in this agreement and to the same extent as if I personally took such steps.
3. I consent and authorize CanaRx to collect my personal medical information and to maintain on file the information necessary to verify and process future orders, including but not limited to my full name, address, phone number, complete medical history and payment information.
4. I authorize my U.S. physician and CanaRx to release any and all information required in connection with my physical condition, including but not limited to all X-rays, medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions and/or any other knowledge or information which they may possess to a CanaRx contracted physician who may be required to review my health record for the purposes of being in a position to evaluate the medical necessity and indications for prescription medication.
5. I authorize the CanaRx contracted physician to contact my U.S. physician to discuss my prescription if necessary.
6. I further authorize the CanaRx contracted physician to issue prescriptions for medications I have ordered only if he/she deems it advisable and appropriate.
7. I further authorize the CanaRx contracted physician to release any and all information that may be required by any CanaRx contracted pharmacy for the purpose of having my prescriptions filled.
8. I further authorize CanaRx to make payments on my behalf to the CanaRx contracted pharmacy for the filling of my prescriptions and to the CanaRx contracted physician for services rendered on my behalf.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgments and releases to *CanaRx*, including all of its employees, its contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. I acknowledge that my U.S. physician is my primary physician and the CanaRx contacted physician is being asked only to review the information contained in the Personal Medical History for the purpose of authorizing any properly prescribed medications for fulfillment from a CanaRx contracted pharmacy.
2. I acknowledge that CanaRx has made no representations or warranties to me, including, without limitation, representations or warranties regarding the use of fitness for any particular purpose of the medications delivered (including, without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease, or its potential or actual side or adverse effects whether previously known or unknown).
3. I acknowledge that I wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx to facilitate this matter. I understand and appreciate that the CanaRx contracted physician will rely on the accuracy of the examination and prescription provided by my U.S. physician.
4. I hereby specifically acknowledge that I am aware that CanaRx may transmit my personal information by electronic means (for example fax, or secure internet) to its agents, contracted physicians and pharmacies. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that CanaRx, as a custodian of my personal information, will take all appropriate precautions to protect my personal information from improper disclosure or use. I hereby consent to CanaRx's transmission of my personal information by electronic means to its agents, contracted physicians and pharmacies.
5. I release CanaRx and all of their officers and directors, agents, employees and contractors from any and all causes of action with respect to errors or omissions by the company or agency responsible for transporting my order.
6. I acknowledge that I have purchased my medications internationally for personal use and understand that my medications may be subject to U.S. border seizure. I specifically confirm, acknowledge and agree that title to my medication passes to me when my medications are shipped from the CanaRx contracted pharmacy.
7. I acknowledge that CanaRx, as my paid agent, requires payment in full prior to shipment and that my order may not be returned for a refund or an exchange.

FURTHER ACKNOWLEDGEMENT & RELEASE

I hereby make the following further acknowledgement and release the plan holder, its employees, officers, agents, heirs and assigns:

1. I acknowledge that the plan holder, has made no representations or warranties to me, including without limitation, representations or warranties regarding the use for any particular purpose the medication (s) delivered, including without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease or its potential or actual side or adverse effects whether previously known or unknown.
2. I acknowledge that child protective packaging may not be used in filling my prescription. I promise that upon my receipt of the medicine I will take all steps necessary to prevent any child from having unauthorized access to the medicine. I hereby release CanaRx Group and all its officer, directors, agents, employees, and contractors, including the pharmacy that fills my prescription, from any and all claims arising from or relating to the use of, or failure to use, child protective packaging in filling my prescription .
3. I release the plan holder its officers, employees, agents, heirs and assigns from (i) any and all causes of actions with respect to errors or omissions by the company or agency responsible for transporting my order; (ii) any and all causes of actions with respect to errors or omissions by CanaRx Group Inc. in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use of any medications delivered through this program which are utilized for any purpose whatsoever.