Ulster Scripts Employee Program

Introduction:

Ulster Scripts is an international mail order option for eligible Employees, Retirees and Dependents of Ulster County, NY, currently covered by your county offered prescription coverage. Your list of qualified maintenance medications is on the reverse.

Co-Payments:

All member co-payments have been **waived** for this program.

Ulster Scripts Vs. Current local purchase plan

Annual Cost No Co-pays		Co-pays	x	Refills	=	Annual Cost
$0	Vs.	**$40** *(PPO)*	x	4	=	**$160 / script**
	Vs.	**$60** *(PPO)*	x	4	=	**$240 / script**
	Vs.	**$40** *(POS)*	x	4	=	**$160 / script**
	Vs.	**$80** *(POS)*	x	4	=	**$320 / script**

Ordering Instructions:

To place your first order simply complete the enrollment form and include a new prescription for each medication. Please allow 20 days 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 taken for 30 days before ordering through **Ulster Scripts.**

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: **Ulster Scripts**
P.O. Box 44650
Detroit, MI 48244-0650

More forms are available:

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

WELCOME TO Ulster Scripts Employee Program

Ulster Scripts Employee Program

For Information: Call 1-866-893-MEDS (6337) — ***International***

- ABILIFY
- ACCOLATE
- ACIPHEX 20MG
- ACTONEL (EXCEPT 75MG)
- ACTOS
- ACTOPLUS 15MG-850MG
- ACULAR LS OPHTH
- ACULAR OPHTH
- **ADALAT CC (G) 60MG**
- ADVAIR DISKUS
- ADVICOR
- AGGRENOX
- **ALDACTONE (G)**
- ALDARA CR
- **ALLEGRA (G) 180MG**
- ALOCRIL OPHTH
- ALPHAGAN-P OPHTH 0.15%
- ALVESCO
- AMERGE 2.5MG
- **ANAPROX DS (G)**
- ARAVA
- ARIMIDEX
- AROMASIN 25MG
- ARTHROTEC
- ASACOL 400MG
- ASMANEX TWISTHALER
- ASTELIN 137MCG
- ATACAND HCT 16/12.5MG
- ATROVENT HFA INH 20UG
- **ATROVENT NASAL (G) 0.06%**
- AVALIDE (EXCEPT 300/25MG)
- AVANDAMET (EXCEPT 1MG/500MG)
- AVANDIA 4 & 8MG
- AVAPRO 75MG
- AVODART
- AXERT 12.5MG
- **AXID (G)**
- AZILECT 1MG
- AZOPT OPHTH DROPS
- BACTROBAN CR
- **BACTROBAN OINT (G)**
- BENICAR HCT
- **BENTYL (G) 20MG**
- **BENZAMYCIN (G)**
- BETOPTIC-S OPHTH
- BONIVA
- **BUSPAR (G) 10MG**
- CADUET 5/10 & 10/20MG
- **CAPOTEN (G)**
- **CARDIZEM CD (G) 180, 240 & 360MG**
- CARDIZEM LA (EXCEPT 240MG)
- **CASODEX (G)**
- **CATAPRES TABS (G)**
- CELEBREX 100 & 200MG
- **CELEXA (G) 20MG**
- CELLCEPT
- CLARINEX 5MG
- COMBIVENT INH 20UG
- COMTAN 200MG
- **CORDARONE (G) 200MG**
- **COREG (G) (NOT CR)**
- **CORGARD (G) 80MG**
- COSOPT OPHTH
- COVERA-HS 240MG
- COZAAR (EXCEPT 25MG)
- CREON 10
- CRESTOR (EXCEPT 40MG)
- CYMBALTA
- **DAYPRO (G)**
- **DDAVP SOL (G)**
- **DDAVP TABS (G)**
- **DEPAKOTE (G) (NOT ER)**
- **DESYREL (G) 150MG**
- DETROL LA 4MG
- DETROL
- **DIDRONEL (G)**
- DIFFERIN
- DIOVAN HCT
- DIOVAN (EXCEPT 40 & 160MG)
- DIPENTUM 250MG
- **DIPROLENE (G)**
- **DITROPAN XL (G) 5 & 10MG**
- DOVONEX CR
- DOVONEX OINT
- DOVENOX SOL
- EFFEXOR XR
- ELIDEL
- ELMIRON
- **ELOCON (G)**
- ENABLEX
- ENTOCORT
- EPIVIR/HBV
- **ESTRACE TABS (G) (EXCEPT 1MG)**
- ESTRADERM PATCH
- EVISTA
- EXELON 3 & 6MG
- **FAMVIR (G) 125MG**
- FEMARA
- FLOMAX TABS 0.4MG
- **FLONASE (G)**
- FLOVENT HFA INH
- FORADIL + AEROLIZER
- FOSAMAX-D 70/2800MG
- FROVA
- GLUCOPHAGE 500 & 850MG
- **GLUCOPHAGE XR (G) 500MG**
- **GLUCOTROL (G)**
- **GLUCOVANCE (G) 500/5MG**
- **HYTRIN (G) (EXCEPT 1MG)**
- HYZAAR 50/12.5MG
- **IMDUR (G) 60 & 120MG**
- IMITREX INJ 6MG/0.5ML
- IMITREX NASAL SPRAY
- **IMITREX TABS (G) (EXCEPT 25MG)**
- **IMURAN (G) 50MG**
- **INDERAL LA (G)**
- **ISOPTIN SR (G) 120 & 240MG**
- JANUMET 50/1000
- JANUVIA
- **KEPPRA (G)**
- **LAMICTAL (G)**
- LAMICTAL DISPERSIBLE
- LAMISIL TABS
- LESCOL XL 80MG
- LESCOL
- LEXAPRO 10 & 20MG
- LIPITOR
- **LOESTRIN 28 (G)**
- **LOPID (G)**
- **LOPRESSOR (G) 50 & 100MG**
- **LOTRISONE CR (G)**
- LUMIGAN OPHTH
- MAXALT MELT 10MG
- MAXALT
- MERIDIA
- **MESTINON (G) 60MG**
- **METROCREAM TOP (G) 0.75%**
- **METROGEL TOP (G) 0.75%**
- METROGEL TOPICAL 1%
- MICARDIS HCT 40/12.5MG
- MICARDIS 40MG
- **MINOCIN (G)**
- MOBIC
- NASACORT AQ
- NASONEX
- **NEURONTIN (G) 100 & 300MG**
- NEXIUM 20 & 40MG
- NIASPAN
- **NORVASC (G) 5 & 10MG**
- OMNARIS NASAL SPRAY
- ORTHO-EVRA
- ORTHO-TRI-CYCLEN LO
- PATANOL OPHTH SOL
- **PAXIL (G) 20 & 30MG**
- PENTASA 500MG
- **PEPCID (G)**
- **PLAQUENIL (G)**
- PLAVIX 75MG
- PRANDIN
- **PRAVACHOL (G)**
- PRECOSE 50MG
- PREMARIN TABS (EXCEPT 0.45 & 0.9MG)
- **PREVACID CAPS (G)**
- PREVACID SOLUTAB
- PRISTIQ 50 & 100MG
- **PROSCAR (G)**
- PROTONIX
- PROTOPIC OINT 0.10%
- PROZAC 10 & 20MG
- PULMICORT TURBU
- **PURINETHOL (G) 50MG**
- QVAR INH
- RANEXA
- RAZADYNE ER 8 & 16MG
- RELAFEN
- RELPAX
- **REMERON (G) 30MG**
- **REMERON SOL (G)**
- **REQUIP (G) 0.25MG**
- **RETIN-A CR (G)**
- **RETIN-A GEL (G)**
- RETIN-A MICRO
- RHINOCORT AQ
- RIDAURA
- **RISPERDAL (G)**
- **RYTHMOL (G)**
- SANCTURA 20MG
- SEREVENT DISKUS
- SEROQUEL
- SEROQUEL XR 50 & 200MG
- **SINEMET (G)**
- **SINEMET CR (G) 200/50MG**
- SINGULAIR
- SORIATANE
- SPIRIVA
- STALEVO
- STARLIX
- TARKA 2/180MG
- TAZORAC CREAM 0.10%
- TAZORAC GEL
- **TEGRETOL (G)**
- **TEGRETOL XR (G)**
- **TEMOVATE (G)**
- **TENORETIC (G) 100/25MG**
- **TENORMIN (G) 100MG**
- TEVETEN HCT 600/12.5 MG
- TEVETEN
- **TIAZAC (G) 300MG**
- **TOPAMAX (G)**
- **TOPROL XL (G) 200 MG (LOPRESSOR SR SUPPLIED)**
- TRAVATAN OPHTH SOL
- TRAVATAN Z OPHTH
- TRICOR 145MG
- **TRILEPTAL TABS (G)**
- ULTRASE MT20
- **UNIPHYL (G)**
- UROXATRAL
- URSO
- VAGIFEM
- **VALTREX (G) 500MG**
- **VASOTEC (G)**
- VESICARE
- **VIVELLE-DOT (G) 25, 50, 75 & 100MCG**
- VIVELLE-DOT 37.5MCG
- VYTORIN 10/20MG
- **WELLBUTRIN XL (G) 150 & 300MG**
- XYZAL 5MG
- YAZ
- **ZADITOR OPHTH (G)**
- **ZANAFLEX (G)**
- ZANTAC
- ZEBETA
- ZESTRIL 20MG
- ZETIA
- **ZOCOR (G)**
- **ZOFRAN (G)**
- **ZOFRAN ODT (G)**
- **ZOLOFT (G)**
- ZOMIG ZMT
- ZOMIG
- ZOVIRAX CR
- ZOVIRAX OINT
- **ZOVIRAX TABS (G)**
- ZYPREXA

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.

This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.

June 2010

Ulster Scripts Employee Program

CanaRx
Employee Enrollment Form

MEMBER ID #.

FAX **DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION (S) TOLL-FREE TO: 1-866-715-(MEDS) 6337**
OR
MAIL **TO: Ulster Scripts , 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)**

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. *Ex. Lipitor* ***(This is NOT a prescription.)***	**Strength** *Ex. 10 mg*	**Reason for Taking** *Ex. Cholesterol*	**Daily Use** *Ex. Twice Daily*

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) Hospitalization: (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: _____

Physician's Name: **Signature:** *(optional)* **Date:** (*DD/MM/YY*)

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 Ulster County, NY, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Subscriber Signature: **Date:** (*DD/MM/YY*)

TERMS OF AGREEMENT

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 acknowledge that child protective packaging may not be used by the CanaRx contracted pharmacy filling my prescription and 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 by the pharmacies 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.

Ulster Scripts Employee Program

CanaRx
Dependent Enrollment Form

MEMBER ID #:

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

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

Phone (Home) Phone (Work)

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. *Ex. Lipitor* *(This is NOT a prescription.)*	Strength *Ex. 10 mg*	Reason for Taking *Ex. Cholesterol*	Daily Use *Ex. Twice Daily*

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) Hospitalization: (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: _____

Physician's Name: Signature: *(optional)* Date: (*DD/MM/YY*)

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 Ulster County, NY, 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 Ulster County, NY, 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*)

TERMS OF AGREEMENT

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 acknowledge that child protective packaging may not be used by the CanaRx contracted pharmacy filling my prescription and 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 by the pharmacies 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.