Application

Instructions: **Please respond to ALL questions**. You must use a **#2 pencil or black ink pen**. The individual boxes should be completely filled in. Do not cross zeroes or sevens.

Yes, I'd like to be considered for the Orange Card℠. I understand that the card is absolutely free.

Please fill in all information:

First Name

Last Name

Address

City

State

ZIP

Phone - -

Gender ☐ Male ☐ Female

Are you enrolled in insurance or a government program or any other private program **that pays for prescriptions** (such as: private insurance, employer plan, Medigap, HMO, Medicaid, state assistance program, other)?

☐ Yes ☐ No

Date of Birth / / (Month / Day / Year)

Medicare # - - -

Are you over the age of 18 and receiving disability payments under Social Security Disability?

☐ Yes ☐ No

ANNUAL HOUSEHOLD INCOME

If you are married and reside with your spouse, you must include both incomes regardless of filing status.

☐ Total number of dependents including yourself, in the household.

Please provide your most recent adjusted gross income from your last Federal Income Tax Return. If you did not file a tax return due to minimum filing requirements, please estimate your household income.

Income $,

CERTIFICATION

I certify that the information on this application form is accurate and complete. I understand and agree that GlaxoSmithKline or its administrator of the Orange Card Program may contact me in the future to verify this information.

ELIGIBILITY

I understand that to be eligible for the Orange Card Program, I must: (i) be a Medicare enrollee at least 65 years of age or Medicare-eligible due to disability; (ii) meet the income requirements established by GlaxoSmithKline; and (iii) not have any public or private insurance coverage for prescription medicines.

LIMITATIONS

The discounts offered under the Orange Card Program are not valid for any prescriptions reimbursed under any federal healthcare program, including Medicare or Medicaid, or any similar federal or state programs, including any state pharmaceutical assistance program (a "Government Healthcare Program"), or under any private insurance, HMO, Medigap, employer, or other third-party payment arrangement ("Private Insurance"). In other words, Orange Card Participants may receive a discount on GlaxoSmithKline prescription medicines only if paying "cash" (eg, they are not eligible to receive third-party reimbursement under any Government Healthcare Program or Private Insurance for the prescription). By my signature on this application, I certify that I am not eligible for and will not be reimbursed by any Government Healthcare Program or by any Private Insurance for any prescription on which I receive an Orange Card discount.

The Orange Card is for use with outpatient GlaxoSmithKline prescription medicines only. The Program does not provide discounts on vaccines, or on products distributed and/or marketed by other manufacturers. The Orange Card may not be used in combination with any other coupon, prescription drug card, or discount for the purchase of GlaxoSmithKline products. The Orange Card is void where prohibited by law, and void outside the USA, or where taxed, restricted, prohibited, assigned, or transferred. GlaxoSmithKline reserves the right to rescind, revoke, or amend the Orange Card Program and the discounts offered under the Program at any time.

DISCLOSURE OF INFORMATION FOR ORANGE CARD ADMINISTRATION

I understand that when I use my Orange Card, an administrator for the Program under contract with GlaxoSmithKline, currently Express Scripts Inc. ("Administrator"), will review my application, notify me regarding my eligibility, and process the discounts provided to me under the Orange Card Program. As part of the application and discount processing, the Administrator will receive information on the prescription medicines my doctor has prescribed for me and other personal information about me that I disclose on the application form. I authorize the Administrator to use this information for purposes related to administering the Orange Card Program. I further authorize the Administrator and GlaxoSmithKline to share and use the information I provide on this application form for purposes related to administering the Orange Card Program. This authorization will expire when I am no longer eligible to participate in the Orange Card Program or upon the termination of the Orange Card Program. I may revoke this authorization at any time by writing the Administrator at the address provided by the Administrator in my Orange Card membership packet, which I will receive with my Orange Card if I am eligible. I understand that if I revoke this authorization, I will no longer be able to participate in the Orange Card Program.

Signature

Date / / (Month / Day / Year)