ORCHARD ENROLLMENT FORM

Group Number: _____ Member ID Number: _____

Name (Last) (First) (M.I.)

_____

Address:

_____

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

Daytime Area Code and Phone #

Cell Area Code and Phone #

State Zip Code

OTHER FAMILY MEMBERS ELIGIBLE FOR DRUG PROGRAM

Family Members	First Name	MI	Last Name	Date of Birth	Sex
Spouse:					
Dependent 1:					
Dependent 2:					
Dependent 3:					
Other:					

OTHER FAMILY MEMBERS ELIGIBLE FOR DRUG PROGRAM

	ALLERGIES					INDIVIDUAL INFORMATION	
	None	Penicillin	Sulfa	Other	Other	Cell Phone	Email Address
Member:						( ) -	
Spouse:						( ) -	
Dependent 1:						( ) -	
Dependent 2:						( ) -	
Dependent 3:						( ) -	
Other:						( ) -	

PAYMENT METHODS: ☐ Visa ☐ Mastercard ☐ Discover ☐ Money Order ☐ Check

Credit Card Number: Exp. Date CVV The 3 or 4 digit security code on the back of the card.

AUTHORIZATION

PLEASE READ AND SIGN: I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor, and I AUTHORIZE ORCHARD PHARMACEUTICALS TO SUBSTITUTE FDA APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSABLE AND CONSISTENT WITH MY PHYSICIAN'S ORDERS AND MY BENEFIT PLAN.

Orchard PHARMACEUTICAL SERVICES

Signature: _____ Date: _____