Introduction:
UCEofFITMeds is a voluntary prescription drug program that is available to eligible members and their dependents of the United College Employees of the Fashion Institute of Technology Welfare Trust Fund. 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.

<table>
<thead>
<tr>
<th>UCEofFITMeds</th>
<th>Vs.</th>
<th>Current Purchase Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Cost</td>
<td>No Copays!</td>
<td>Mail Order Copays</td>
</tr>
<tr>
<td>$0</td>
<td>Vs. $60 (Tier 2)</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Vs. $100 (Tier 3)</td>
<td>x</td>
</tr>
</tbody>
</table>

Ordering Instructions:
To place your first order please submit: a completed enrollment form; a new prescription for each medication; and a copy of your photo identification*.

*Similar to a number of states in the US, some CanaRx pharmacies require a copy of photo ID be provided prior to dispensing the medications. In order to prevent order delays, we encourage patients to include a clear copy of their photo identification with their enrollment form or upload directly to our secure site www.CanaRxDocs.com. If not included, a CanaRx representative will contact you when required by the pharmacy dispensing your medications.

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. Please allow 4 weeks for delivery.

Medications must be tried for 30 days before ordering through UCEofFITMeds.

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:** UCEofFITMeds
235 Eugenie St. West
Suite 105D
Windsor, ON, Canada N8X 2X7

P.O. Box 44650
Detroit, MI 48244-0650
(This P.O. Box is used for expediting all communications crossing the border.)

More forms are available:
Additional forms may be obtained by printing them from the website at www.UCEofFITMeds.com or by contacting our Customer Service Representatives toll free at 1-866-893-(MEDS) 6337.
CONFIRMATION AND REPRESENTATIONS
I enter into this agreement with CanaRx Services Inc. at Windsor, Ontario, Canada, and CanaRx Group Inc. at Christ Church, Barbados (collectively referred to as “CanaRx”) so that I may obtain access to medically-necessary and lawfully prescribed drugs at low costs.

I represent:
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. I certify that I am a resident of the United States and not a resident of any other country.
4. I am a duly qualified and licensed physician in the United States (my “U.S. physician”) and the medicine that I ask CanaRx to assist me in obtaining was prescribed for me by my U.S. physician.
5. My U.S. physician has examined me within the last 12 months and will examine me at least once every 12 months while I am taking medicine.
6. Any medicine that I ask CanaRx to assist me in obtaining is medicine that I have already taken, under my U.S. physician’s orders and supervision, for at least 30 days prior to placing an order for the medicine through CanaRx.
7. My care by my U.S. physician is ongoing and I do not seek and will not rely on any medical information from CanaRx or any CanaRx contracted physician.
8. I have not violated any laws in the jurisdiction in which I ordinarily reside (or, if different, in the jurisdiction in which the prescription was issued) in obtaining the prescription for the ordered product.
9. The prescription issued by my U.S. physician has not been altered in any way nor has it been filled previously.
10. I will use any medications obtained for me through CanaRx strictly in accordance with the instructions provided by my U.S. physician.
11. The medicine dispensed in accordance with my prescription will not be used in any way whatsoever except as directed by my U.S. physician.
12. I will not permit anyone else to use the prescription or any medications which I receive.
13. In the event that I suffer any side effects from any medication obtained for me by CanaRx, I will immediately contact my U.S. physician.
14. All information that I give to CanaRx is true.

AUTHORIZATION AND CONSENT
I consent to, and authorize, the following:
1. I hereby appoint CanaRx and its delegates and contractors (collectively referred to as “CanaRx”) as my paid agents and attorneys-in-fact for the purposes of obtaining prescriptions which correspond to the prescriptions issued by my U.S. physician and of arranging for pharmacies to dispense to me medications as prescribed.
2. CanaRx may perform any act that I could myself perform in having my prescription reviewed by any physician, pharmacist, or pharmacy technician and in having the prescribed medication dispensed by a pharmacy and delivered to me.
3. CanaRx may arrange the purchase and delivery of the medications prescribed to me, on the terms set forth in this agreement, as if I personally took such actions.
4. I authorize and instruct my U.S. physician to release to CanaRx (and any CanaRx contracted physician, pharmacist, and pharmacy technician) any and all personal medical information pertaining to me (“Personal Medical History”), including but not limited to all medical records, medical reports, progress notes, nurses’ notes, reports on diagnostic tests, medical opinions, X-ray records, imaging records, laboratory reports, and/or any other knowledge or information which my U.S. physician may possess.
5. I agree to instruct my U.S. physician to issue my prescription on paper (necessarily for dispensing by a pharmacy located outside my U.S. physician’s jurisdiction) and to send (by mail, by fax, via the internet or otherwise) to CanaRx from my U.S. physician’s office the original signed copy of the prescription.
6. CanaRx and its contracted physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
7. CanaRx contracted physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
8. CanaRx may make payments on my behalf to CanaRx contracted pharmacies for dispensing medicine in accordance with my prescriptions and to CanaRx contracted physicians for services rendered on my behalf.
9. I request and authorize my employer or plan holder, as my appointed agent, to pay for all products and services relating to the prescription medicine that I obtain through CanaRx in such amounts as are found appropriate by my employer or plan holder in accordance with the benefits plan.

ACKNOWLEDGEMENT AND RELEASE
I hereby make the following acknowledgements and releases to CanaRx and all its employees, delegates, agents, and contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:
1. My U.S. physician is my primary physician. Any CanaRx contracted physician is being asked to review the information contained in my Personal Medical History only for the purpose of authorizing the medicine prescribed for me by my U.S. physician to be dispensed to me by a CanaRx contracted pharmacy.
2. 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 wish to obtain a prescription from a CanaRx contracted physician and have enlisted the services of CanaRx to facilitate it. I understand that the CanaRx contracted physician will rely on the accuracy of the examination performed, and the prescription provided by, my U.S. physician.
4. I release CanaRx and all of its officers and directors, agents, delegates, employees and contractors from any and all liability, claims, and causes of action with respect to errors, commissions by the company or agency responsible for transporting my order.
5. I acknowledge that I have purchased my medications internationally for personal use and understand that my medications may be subject to U.S. border inspection. I specifically confirm, and agree that title to my medications passes to me when my medications are shipped from the CanaRx contracted pharmacy.
6. 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.

PRIVACY NOTICE AND ACKNOWLEDGEMENT
I consent to the following terms regarding the collection and use of information about me, and I acknowledge that I can review the CanaRx Privacy Policy in detail as provided below:
1. CanaRx may receive and collect any and all information about me and my health, including but not limited to my full name, address, telephone number, e-mail address, Social Security number, personal medical information, and payment information, and may maintain such information on file as necessary to verify and process future orders and to obtain payment and reimbursement for them. CanaRx and CanaRx contracted physicians and pharmacists may share any and all information received from or about me with my U.S. physician, CanaRx contracted physicians and pharmacists, and my employer or benefits plan administrator, and their respective assistants and agents. I hereby release CanaRx and all of its officers, directors, agents, delegates, employees, 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.
2. CanaRx may transmit my personal information by electronic means (for example, fax, or via the internet) to its agents, contracted physicians and pharmacists. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that CanaRx may, as a custodian of my personal information, 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 delegates, employees, contracted physicians and pharmacists.
3. I acknowledge that CanaRx will obtain health information about me, and is obligated in accordance with the CanaRx Privacy Policy to protect such information. I can visit www.CanaRx.com at any time to view the most updated version of the CanaRx Privacy Policy.

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 of 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. Under any circumstances I will release CanaRx to any and all officers, directors, agents, delegates, employees, 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.
3. I release the plan holder its officers, employees, 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 in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use for any purpose whatsoever of any medications delivered through this program.
List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. *(THIS IS NOT A PRESCRIPTION.)*

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Dosage</th>
<th>Time(s) to Take</th>
<th>Date Started</th>
<th>Reason for Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex. Januvia</td>
<td>Ex. 50mg</td>
<td>Ex. Twice Daily</td>
<td>Ex. 8/20/2017</td>
<td>Ex. Diabetes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

(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 Dependents 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, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided above is accurate and true.

Parent’s/Guardian’s Signature: ______________________ Date: (MM/DD/YY)

AUTHORIZATION IF THE PATIENT IS THE SUBSCRIBER, SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER
I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided by me is accurate and true.

Patient Signature: ______________________ Date: (MM/DD/YY)

October 2019