

\_\_\_\_ (11 DIGIT#)

\*Please complete and return to your Pharmacist  
(Pharmacist, please check if applicable)  MAY CONTAIN MERGED DATA

The Live Better! Wellness Club™ offers its members value added services specific to their health and wellness needs. As part of the Live Better! Wellness Club™ we offer a Generic Prescription Program for individuals and families who are: (a) uninsured or (b) otherwise not utilizing prescription drug benefits for the generic drugs included in this program. A list of the generic drugs included in the program is available at the Pharmacy. All information provided by you will be kept confidential in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"). Only certified HIPAA trained individuals will have the right to review your information or send communication to you based on your authorized signature below.

**PLEASE COMPLETE**

By enrolling in the Live Better! Wellness Club™ you will receive discounts storewide and be eligible for the Live Better! Generic Prescription Program.

- ENROLLED**
- Live Better! Wellness Club™ = \$9.99**

Name (as it appears on shoppers card) \_\_\_\_\_  
LAST FIRST MI

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender  Male  Female

Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

E-Mail Address: \_\_\_\_\_

**LIVE BETTER! GENERIC PRESCRIPTION PROGRAM**

By checking this box, you agree to become a member of our Live Better! Generic Prescription Program. You also verify that you are (a) uninsured or (b) otherwise not utilizing prescription drug benefits for the generic drugs included in the program. A list of the included generic drugs is available at the Pharmacy.

\*A separate [PH04] Confidential Patient Profile form must be completed for each additional Family member.

**LIVE BETTER! WELLNESS CLUB™**

Would you like to receive up-to-date educational information and store specials about your interests and health concerns?	Yes _____ No _____
Would you like to receive healthy recipes?	Yes _____ No _____
Are you interested in participating in a nutritional supermarket tour?	Yes _____ No _____
How would you prefer to receive written information?	Mail _____ E-mail _____

**NUTRITIONAL INTERESTS (please check all that apply):**

- Fat Free or Low Fat Foods
- Food Allergy (specify) \_\_\_\_\_
- Gluten Free Foods
- Gluten Free (no cross contamination)
- Lactose Intolerance
- Low Carbohydrate Foods
- Low cholesterol foods
- High Fiber Foods
- Reduced Sugar Foods
- Reduced Sodium or Low Sodium Foods
- Nut Free Foods



**HEALTH ISSUES THAT ARE OF INTEREST TO YOU. Please check all that apply.**

<input type="checkbox"/> Acne	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Mouth/Throat Problems, Long Term
<input type="checkbox"/> Alcohol Dependence	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Muscular/Neuromuscular Problems
<input type="checkbox"/> Allergy	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Obesity
<input type="checkbox"/> Anemia	<input type="checkbox"/> Erectile Dysfunction (ED)	<input type="checkbox"/> Osteopenia
<input type="checkbox"/> Angina	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fibroid Cysts	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Peripheral Vascular Disease (PVD)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gastrointestinal Problem	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Prostate condition, BPH
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Gout	<input type="checkbox"/> Psychoses
<input type="checkbox"/> Blood Clotting Disorders	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Pulmonary Diseases / COPD
<input type="checkbox"/> Blood Dyscrasias	<input type="checkbox"/> Heart Arrhythmias	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Blood Pressure, High	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Shingles Sleep Disorders
<input type="checkbox"/> Blood Pressure, Low	<input type="checkbox"/> Heart Failure, Congestive	<input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> Breast Feeding	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Thyroid, Overactive
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Thyroid, Underactive
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> Ulcerative Colitis Ulcers
<input type="checkbox"/> Dementia	<input type="checkbox"/> Liver Disorders	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Depression	<input type="checkbox"/> Lupus Erythematosus	<input type="checkbox"/> Upper Respiratory Problems
<input type="checkbox"/> Depression, Manic	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Dermatologic Disorders	<input type="checkbox"/> Menopause	<input type="checkbox"/> Weight Over
<input type="checkbox"/> Diabetes, Type 1	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Weight Under
<input type="checkbox"/> Diabetes, Type 2	<input type="checkbox"/> Mitral Valve Disease	<input type="checkbox"/> Ear Infection, Long Term
<input type="checkbox"/> Other(please specify): _____		

**PAIN RELIEVERS, VITAMINS OR HERBAL SUPPLEMENTS THAT ARE OF INTEREST TO YOU**

<input type="checkbox"/> ACETAMINOPHEN (i.e., TYLENOL®)	<input type="checkbox"/> GINKGO BILOBA	<input type="checkbox"/> NAPROXEN (i.e., ALEVE®)
<input type="checkbox"/> ASPIRIN (i.e., BAYER®)	<input type="checkbox"/> GINSENG	<input type="checkbox"/> ST. JOHN'S WORT
<input type="checkbox"/> CALCIUM	<input type="checkbox"/> IBUPROFEN (i.e., ADVIL®)	<input type="checkbox"/> VITAMIN B
<input type="checkbox"/> ECHINACEA	<input type="checkbox"/> IRON SUPPLEMENT	<input type="checkbox"/> VITAMIN C
<input type="checkbox"/> GARLIC	<input type="checkbox"/> MULTI-VITAMIN	<input type="checkbox"/> VITAMIN E
<input type="checkbox"/> OTHER (Please Specify) _____		

**Please check all that apply (optional):**

<input type="checkbox"/> I have cat(s)	<input type="checkbox"/> I have dog(s)	<input type="checkbox"/> I am a smoker	<input type="checkbox"/> I have sensitive teeth
<input type="checkbox"/> I have dentures	<input type="checkbox"/> I have a newborn 0-12 mos.	<input type="checkbox"/> I have a toddler 1-5yrs. old	

Member Signature (all members must sign): \_\_\_\_\_ Date: \_\_\_\_\_

Member Name (Please Print): \_\_\_\_\_ Type of ID given: \_\_\_\_\_

If under 18 years old.

Personal Representative's Name \_\_\_\_\_

Relationship to Customer \_\_\_\_\_

I understand that I may revoke this Authorization in writing at any time by sending a letter to The Great Atlantic & Pacific Tea Company 2 Paragon Drive Montvale, NJ 07645 Attn: Sr. Director of Pharmacy, except to the extent that the Pharmacy has taken action in reliance on its authorization. The enrollment fee is non-refundable. **This Authorization ends on December 31, 2008 unless otherwise designated.**

I authorize (Personal Representative's Name) \_\_\_\_\_, (Relationship to Customer) \_\_\_\_\_, to use my bonus card and receive information on my behalf.

Family Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_