

Rx AMERICA DRUG CARD ENROLLMENT FORM

For BPCF Use Only	
Effective Date / /	Group No. 0641001
Full Time Hire Date / /	Sublocation

Mail or Fax to:
 BPC Financial
 7645 Gate Parkway, Suite 101
 Jacksonville, FL 32256
 Toll Free (800) 282-8626
 Fax (904) 396-2091

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: _____ <small>(Last, First, Middle)</small>			
Mailing Address: _____ <small>(Street Address)</small>			
_____	_____	_____	_____
<small>(City)</small>	<small>(State)</small>	<small>(Zip)</small>	<small>(Pay period - if applicable)</small>
Social Security # _____	Date of Birth: _____		
	<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Name of Employer/Group <u>The Florida Bar</u>	FL Bar # _____		
Email address: _____	Phone # (____) _____		
Member of the Florida Bar <input type="checkbox"/>	Employee of Florida Bar Member <input type="checkbox"/>		

Dependent Information

(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF

	Add	Delete	Male	Female	Date of Birth:		
Spouse: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
					<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
					<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
					<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
					<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
					<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>
Dependent: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
					<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>

I certify that the information in this form is true and correct to the best of my ability.

Signature of Enrollee _____

Date _____