DRL
Doyle Rowe LTD

IMRF Endorsed Sav-Rx Advantage Prescription Drug Discount Card

Receive discounts on your prescription medications at more than 50,000 member pharmacies nationwide, including most chain pharmacies.

Always pay the lowest price for your prescriptions. Average savings range from 15% to 40%. Discounts vary by medication and may be less than the average or greater than the average for your particular medications.

Includes a mail order option – receive even greater discounts on prescriptions through mail order pharmacy.

Not a Part D plan, but can be used for prescriptions that are not covered under your Part D plan or during the coverage gap.

Easy to use – present your Sav-Rx Advantage card at any member pharmacy. The pharmacy will run your card through the Sav-Rx system and charge you the discounted price when you receive your prescription - it's that simple.

Low IMRF Group Rate – The Sav-Rx Advantage card is available to IMRF members, their spouses and dependent children under the age of 23 for only $1.50 per application per month. The monthly cost of the program will be deducted from your IMRF benefit payment.

How to enroll - Complete the enclosed premium deduction authorization and mail it to Doyle Rowe LTD, 1301 W. 22nd Street, Suite 101, Oak Brook, IL 60523. Coverage will become effective on the first of the month following receipt of your application (if received before the 25th of the month). Your Sav-Rx Advantage card will be mailed to your home before your first month's effective date. Your monthly cost of $1.50 will be deducted from your IMRF benefit payment each month beginning the month your membership becomes effective.

Questions – Contact the Doyle Rowe LTD Enrollment Hotline at 1-800-564-7227 between the hours of 8:30 a.m. to 4:30 p.m. CST Monday through Friday. Or visit them online at www.doylerowe.com.

Health Care Program Premium Deduction Authorization for IMRF-endorsed Plans

IMRF Form 7.10E (Rev. 08/2013)

- Please indicate which program you are **NEWLY** applying for by checking the appropriate box(es) below.
- Fill out the front page of this form only; the back page will be filled out by the plan administrator.
- **Please note**: All programs except for Sav-Rx **require additional applications**.
- **Return completed form to**: Doyle Rowe Ltd.,1301 W. 22nd Street, Suite 101, Oak Brook, IL 60523.
- **If you have any questions contact Doyle Rowe at 1-800-564-7227 or www.doylerowe.com.**

PLEASE PRINT OR TYPE

MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	IMRF MEMBER ID OR LAST 4 DIGITS OF SSN

(If applicable) SPOUSE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
	___ - ___ - ___

HOME STREET (MAILING) ADDRESS

CITY, STATE, AND ZIP	DAYTIME TELEPHONE NUMBER (with Area Code)
	( )

To be completed by applicant. Please note that all programs except Sav-Rx require a separate application form. CHECK ONLY THE PLAN YOU ARE NEWLY ENROLLING IN.

Seniors Choice	☐ Individual	☐ Spouse	**Humana Local PPO**	☐ Individual	☐ Spouse
United Health Care Medicare Complete	☐ Individual	☐ Spouse	**Humana Regional PPO**	☐ Individual	☐ Spouse
Health Care Alliance HMO	☐ Individual	☐ Spouse	**Humana Group PDP Plan**	☐ Individual	☐ Spouse
Health Care Alliance PPO	☐ Individual	☐ Spouse	**Sav-Rx Advantage Card**	☐ Individual	☐ Spouse
Blue Cross Blue Shield of Illinois	☐ Individual	☐ Spouse	**Delta Dental of Illinois**	☐ Individual ☐ Spouse	☐ Family
Blue Cross Blue Shield of Texas	☐ Individual	☐ Spouse	**United Health Care Vision Plan**	☐ Individual ☐ Spouse	☐ Family

Member Authorization

I authorize and request the Illinois Municipal Retirement Fund (IMRF) to deduct premiums for the selected program(s) from my IMRF benefit payment and to remit the amount deducted to the health care program. I authorize IMRF to release information to the health care program in order to ensure proper handling of premiums. I understand IMRF will adjust deductions in response to changes in the premiums. I further understand that IMRF will cease making any deduction if the premiums exceed my IMRF benefit amount. This authorization is not an assignment of my right to receive payment. This authorization will remain in effect with IMRF until cancelled by written notice from me or until IMRF is notified that a premium deduction is no longer required.

MEMBER SIGNATURE* DATE (MM/DD/YYYY) SPOUSE'S SIGNATURE DATE (MM/DD/YYYY)

***Member signs if member is receiving benefit payment; Spouse signs if spouse is receiving surviving spouse benefit or if spouse is enrolling in the Sav-Rx Advantage Card program.**

FOR IMRF USE ONLY	Date Entered	Date Effective