



Phillips Exeter Academy
2009-2010 PRESCRIPTION BENEFIT FORM

SECTION III: PRESCRIPTION BENEFIT CARD

Please make a clear copy of the front and back of your prescription card and enclose them with this form.

Prescription Card (front)

Prescription Card (back)

Your billing address zip code: _____

PHARMACY PAYMENT:

I hereby authorize payment to a pharmacy, designated by Phillips Exeter Academy, of any co-payments or unpaid balances after insurance, for medications provided to my child. Please be aware that health insurance does not cover over-the-counter medications.

Charge to: _____ American Express _____ Master Card _____ Visa _____ Discover

Card number: _____ Expiration Date: _____

SIGNATURE OF CARDHOLDER

CARDHOLDER NAME

DATE

Form Due Date: **August 1st** (returning students)

Phillips Exeter Academy
Lamont Health and Wellness Center
20 Main Street
Exeter, NH 03833
Telephone: 603-777-3420
Fax: 603-777-4391