MY SAVOY BENEFITS

Prescription Medications

Name:
Phone number:
Email address:

Please enter your prescription-related information below (*all information can be found on the labels of your medications*) and return via email for further enrollment assistance.

Medication Information					
Drug name (e.g., Crestor)	**Quantity (e.g., 90)**	**Dosage (e.g., 20mg)**	**Frequency (e.g., Daily)**	**Is generic medication okay? (Choose Yes or No)**	
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
Home zip code:					
Preferred pharmacy (name and address):			**Secondary pharmacy** (name and address):		

By signing below, I authorize to have a licensed / certified insurance agent contact me directly to discuss these Part D (Rx) options.

_____ _____

Signature **Date**

Please return the completed form via email to: **rps.benefits.experts@rpsins.com**
If you have any questions or need assistance, please call **833.899.6200**.