To: Florida EPIC Pharmacies
Re: Voluntary contributions to EPIC PharmPAC of Florida

In 2012, the stockholders of EPIC Pharmacies, Inc. voted to support a Political Action Committee (PAC) called PharmPAC. Its goal is to solicit and accept voluntary contributions from individuals and organizations to be expended to influence the nomination or election of candidates to public office who are concerned or interested in consumer access to, and the survival of, independent community pharmacies in Florida.

In today's rapidly evolving health care environment, it is very important that EPIC Pharmacies, Inc. functions on a par level with those who are diametrically opposed to the issues that are vital to the support of independent pharmacy. Consistent with Florida State Law, it is necessary for all members to individually authorize the gathering of these funds. As a member of EPIC Pharmacies, Inc., we are requesting your support of EPIC PharmPAC of Florida by allowing the office to collect a **minimum of $25 per month.** Please indicate below your billing preference. If you are contributing from your checking account, please fill out the following authorization form for pre-arranged payments.

Thank you for your support in this and all EPIC Pharmacies, Inc. programs. If you have any questions or comments, please feel free to call our office. Kindly fax your response to 410-567-0970 or email to epicpharmacies@epicrx.com.

_____ **YES** – I hereby authorize you to **bill me annually** for my total contribution of **$300** to EPIC PharmPAC funding.

_____ **YES** – I hereby authorize you to **automatically withdraw $150 bi-annually from my checking account** for my yearly contribution of **$300** to EPIC PharmPAC.

_____ **NO** – I do not authorize a contribution to EPIC PharmPAC at this time.

If No, what would encourage you to contribute? _____

_____

Is your pharmacy incorporated? YES NO

Pharmacy Name: _____

NCPDP #: _____

Signature: _____

Print Name: _____

– EPIC PharmPAC EFT–

AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS [DEBITS]

[Please send a copy of a voided check for this account with this form]

PHARMACY CORPORATE NAME: _____

TRADING AS: _____

I hereby authorize **EPIC PharmPAC** to initiate debit entries to my checking account indicated below, and the Financial Institution named below, hereinafter called BANK, to debit the same to such account*.

BANK NAME: _____ BRANCH: _____

CITY: _____ STATE: _____ ZIP: _____

Checking Account: ☐ Savings Account: ☐

BK TRANSIT/ABA NO.: _____ ACCOUNT NO.: _____

This authority is to remain in full force and effect until BANK has received written notification from me of its termination in such time and in such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notification to BANK prior to charging account. After account has been charged, a customer has the right to have the amount of an erroneous debit immediately credited to his account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever occurs first.

PHARMACY CORPORATE NAME: _____

NCPDP #: _____

TRADING AS: _____

DATE: _____ SIGNED NAME: _____

PRINTED NAME: _____

If your account is revised in any manner, please call 1-800-965-EPIC to update your information.