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

In 1994, the stockholders of EPIC Pharmacies, Inc. voted to support a Political Action Committee (PAC) called PharmPAC. At that time, EPIC Pharmacies, Inc. solicited members to contribute financially on behalf of their pharmacy.

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 Indiana 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 Indiana by allowing the office to collect a **minimum of $20 per month. This can be billed annually for a total contribution of $240 or $120 can be automatically withdrawn from your checking account bi-annually.** Please indicate below your billing preference.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 410-567-3786 or email to epicpharmacies@epicrx.com.

_____ **YES** – I hereby authorize you to **bill me annually** for my total contribution of **$240** to EPIC PharmPAC of Indiana funding.

_____ **YES** – I hereby authorize you to **automatically withdraw $120 bi-annually from my checking account** for my yearly contribution of **$240** to EPIC PharmPAC of Indiana.

_____ **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** of Indiana 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: _____

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

Checking Account: ☐ Savings Account: ☐

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: _____

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.