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

EPIC PharmPAC of Michigan was organized with application to the Michigan Board of Elections in 2010. The goal is to solicit and accept voluntary contributions from individuals 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 Michigan.

The PAC makes contributions to legislators and state offices that can have an impact on independent pharmacy in Michigan. Especially in this state election year, it is imperative that we have the resources to be a player in these races. We are uniquely positioned this year, because of the activities of our lobbyist, to be noticed and listened to by the legislature.

To have the greatest impact and to allow EPIC PharmPAC of Michigan to respond to the increasing requests for financial support from candidates, funding must also be solicited from EPIC Pharmacies, Inc. members in Michigan.

In accordance with Michigan State Law, contributions that are issued by corporations or LLCs cannot be given to PharmPAC. Contributions can only be made by a **PERSONAL CHECK** or EFT withdrawn from a personal account. As a member of EPIC Pharmacies, Inc., we are requesting your support of EPIC PharmPAC 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 This can be billed annually for a total contribution of $240 or $120 can be automatically withdrawn from your personal checking account bi-annually.** Please indicate below your billing preference. If you are contributing from your personal checking account, please fill out the following authorization form for pre-arranged payments.

Your support of EPIC PharmPAC of Michigan will ensure that the collective voice of independent community pharmacy will be heard loud and clear at the State Capitol in Lansing.

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 **$240** to EPIC PharmPAC funding.

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

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

_____**YES -** I wish to make an immediate contribution of $ _____.

_____ **NO** - I do not authorize you to bill me for 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: _____

PERSONAL NAME ON ACCOUNT: _____

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: _____

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.

PERSONAL NAME ON ACCOUNT: _____

DATE: _____ SIGNED NAME: _____

PRINTED NAME: _____

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