APA Health & Wellness Plan

ENROLLMENT GUIDE 2024

- Health Insurance
- Dental Insurance
- Vision Insurance

Providers Include:

BCBS of Alabama

Guardian Dental & VSP Vision

For More Information

kelly@aparx.org

The following is provided for your use as a **CHECKLIST** to ensure that your insurance application is complete when received and ready to be processed.

IMPORTANT: All paperwork must be sent to the APA office. Any paperwork received by BCBS, Guardian Dental & VSP Vision will not be processed.

1. **Blue Cross & Blue Shield Application for health and/or dental (if applicable)**

2. **VSP Vision & Guardian Dental Application (if applicable)**

3. **Automatic Bank Draft Authorization**: Required for payment of insurance premiums. *(Only owner needs to complete if signing up a new division; will directly send to owner)*

4. **Verification of Employment and Eligibility Form**

5. **Insurance Information Request Form** (date of employment **MUST** be included)

6. **Membership Application** (All pharmacists and pharmacy technicians must be a current APA member to participate in the insurance program.)

Your completed insurance application will be processed when received. It is extremely important that you double check and be certain that you have included all of the items above, and that all applications and forms are filled out completely, signed and dated.

Submitting incomplete applications may delay your insurance coverage. Take an extra minute to look over your application(s) before submitting them to APA.

All summary plan descriptions are available at your request from the APA office, as a standard practice, these booklets will be emailed to the new enrollee.

Sincerely,

Kelly

Kelly Findley
Director of Insurance & Member Benefits

1211 Carmichael Way Montgomery, AL 36106-3672 Tel: (334) 271-4222 Fax: (334)271-5423

APA Group Insurance Program
Verification of Employment and Eligibility

The criteria for eligibility in this group insurance program is very specific. It is extremely important that both the **employer** and the **employee** understand their responsibility in adhering to the eligibility requirements, as well as the liability each incurs if individuals are **NOT** a legal spouse or dependent of the applicant.

CRITERIA FOR INSURANCE PROGRAM:

1. Effective August 1, 2014, licensed pharmacists and pharmacy technicians, who are members of APA and keep their license and membership dues current are eligible to participate through a participating store currently enrolled OR as a new insurance division. (If you are a pharmacist or pharmacy technician you **must** be a member of APA to participate on the insurance plan). APA is pleased to be able to offer the option for pharmacist members to utilize quarterly installment payments for their annual dues; however, those choosing to take advantage of this option are still responsible for the entire amount of $250, even if their insurance coverage through APA is cancelled.

2. To be eligible to participate in APA's insurance program, you must work at least **30 hours per week**.

3. Full-time and part-time employees of a participating pharmacy are eligible to participate. An employee must enroll within the first 30 days of employment for new hire status. Employees who do not enroll within 30 days of employment will have to wait to enroll during open enrollment (January) unless the employee has a qualifying life event such as marriage, divorce, loss of coverage, etc. In that case, the employee must enroll within 30 days of the qualifying event.

4. In the event of a policyholder's death, dependents of the deceased are no longer eligible to participate in APA's insurance program unless the dependents are employees of a participating pharmacy. COBRA coverage would be available only.

5. Family Coverage can include your spouse and/or legal dependents until they are 26 years old, married or single.

The employer is responsible for all insurance applications submitted from his or her pharmacy. If it is determined that an individual on your insurance billing does NOT meet the eligibility requirements, his or her coverage will be canceled immediately, and any claims that have been paid for that employee will have to be repaid to the insurance company.

By signing this verification of employment and eligibility, the applicant (employee) and the employer acknowledges that they have read the criteria, understand their responsibility and liability, and confirm applicants' employment and eligibility to participate in the Group Insurance Program.

_____ _____

Employee Signature License # Date Signed

_____ _____

Employer Signature License # Date Signed

APA Health Insurance Program
Insurance Information Request

This form must be completed and returned with your insurance applications. Your insurance applications will not be processed without this completed and signed form. ***Please print all information.***

APPLICANTS NAME: _____

APPLICANTS HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: Work (___)_____Cell #: (___)_____ **Required**

FAX #: Work (___)_____ EMAIL:_____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____

POSITION (*Check One*): ___Pharmacist ___ Pharmacy Technician ___ Other

LISCENSE #: _____ PHARMACY OWNER: _____YES _____NO

APA Member: ___ YES ___ NO ***(Pharmacists & Technicians are required to join APA to be eligible to participate in the insurance program)***

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHARMACY EMAIL: _____

DATE EMPLOYED: _____/_____/_____ FULL-TIME?: _____YES_____NO

******COVERAGE EFFECTIVE DATE: _____/_____/_____******

IMPORTANT: *Please circle below which tier that you are electing [Single}, {Employee + Spouse}, {Employee + Children} or {Family} Note, children are eligible for coverage until 26 years of age, single or married.*

BCBS Health Platinum	***BCBS Blue Secure 2000***	***BCBS Blue Saver 3000***
Single	*Single*	*Single*
Employee + 1	*Employee + 1*	*Employee + 1*
Employee + Children	*Employee + Children*	*Employee + Children*
Family	*Family*	*Family*

List other elective coverage that is selected (ie, BCBS Basic Dental, BCBS Blue Dental 1000A, Guardian Dental & VSP Vision – Specify which plan below for multi option plans)

2024 RATES

YOUR PLAN, YOUR CHOICE - HEALTH, DENTAL, AND VISION PLANS

BCBS HEALTH	Platinum	Blue Secure 2000	Blue Saver 3000
Single	$582.67	$550.55	$482.57
Employee + Spouse	$1,238.57	$1,168.22	$1,019.38
Employee + Children	$938.80	$887.10	$777.66
Family	$1,370.54	$1,290.10	$1,119.81

BCBS DENTAL	Preferred Dental	Dental Blue 1000A (w/ortho)
Single	$28.83	$36.34
Employee + Spouse	$58.53	$68.88
Employee + Children	$46.42	$89.67
Family	$85.18	$125.41

GUARDIAN DENTAL	OPTION 1 COMPLETE W/ORTHODONTICS	OPTION 2 VALUE W/ORTHODONTICS	OPTION 3 COMPLETE DENTAL	OPTION 4 VALUE DENTAL
Single	$44.12	$39.94	$40.63	$36.43
Employee + Spouse	$66.64	$64.04	$55.16	$50.49
Employee + Children	$77.48	$74.74	$63.89	$59.17
Family	$97.07	$93.96	$79.53	$73.10

VSP VISION	OPTION 1 PREMIUM VISION	OPTION 2 VALUE VISION
Single	$17.00	$14.00
Employee + Spouse	$29.00	$20.00
Employee + Children	$31.00	$17.00
Family	$48.00	$27.00

**Please refer to Summary Plan Desciption to review benefits to select the best health, dental, and vision plan for you and your family.*

Application

For Enrollment with Binding Arbitration

450 Riverchase Parkway East • P. O. Box 995
Birmingham, Alabama 35298-0001

BlueCross BlueShield of Alabama

ENR431-2011

BlueCross BlueShield of Alabama

Application For Enrollment

Fields marked with an * are required fields. Any required information not completed may delay the processing of your application.

EMPLOYEE INFORMATION

*HEALTH GROUP NUMBER	*HEALTH DIVISION NUMBER	*DENTAL GROUP NUMBER	*DENTAL DIVISION NUMBER

***NATURE OF APPLICATION** *(Check all that apply)*

☐ **NEW CONTRACT** ☐ HEALTH ☐ DENTAL

☐ **CANCEL CONTRACT** ☐ HEALTH ☐ DENTAL

☐ **CHANGE CONTRACT** ☐ NAME CHANGE ☐ ADDRESS CHANGE ☐ TYPE COVERAGE CHANGE

ENROLLMENT PERIOD *(for new contracts)*

☐ REGULAR ENROLLMENT ☐ ANNUAL OPEN ENROLLMENT ☐ SPECIAL OPEN ENROLLMENT

***LAST NAME**

***FIRST NAME**

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

***SOCIAL SECURITY NUMBER** – –

***HOME MAILING ADDRESS**

***CITY**

***STATE**

***ZIP**

***PHONE NUMBER** ☐ HOME ☐ WORK ☐ CELL – –

E-MAIL ADDRESS (Optional)

***GENDER** ☐ MALE ☐ FEMALE

***DATE OF BIRTH** (MM/DD/YYYY) / /

***EMPLOYEE NUMBER**

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.
By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

DEPENDENT

***LAST NAME**

***FIRST NAME**

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

***SOCIAL SECURITY NUMBER** – –

***RELATIONSHIP** ☐ CHILD ☐ SPOUSE ☐ OTHER_____

***GENDER** ☐ MALE ☐ FEMALE

***DATE OF BIRTH** (MM/DD/YYYY) / /

☐ **ADD DEPENDENT**

QUALIFYING EVENT TYPE: ☐ Marriage ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other _____

*** DATE EVENT OCCURRED** / /

☐ **REMOVE DEPENDENT**

REMOVE DEPENDENT DUE TO: ☐ Divorce ☐ Death ☐ Entered Military Service ☐ Request

*** DATE EVENT OCCURRED** / /

☐ ADD HEALTH ☐ ADD DENTAL ☐ ADD BOTH

☐ REMOVE HEALTH ☐ REMOVE DENTAL ☐ REMOVE BOTH

DEPENDENT

***LAST NAME**

***FIRST NAME**

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

***SOCIAL SECURITY NUMBER** – –

***RELATIONSHIP** ☐ CHILD ☐ OTHER_____

***GENDER** ☐ MALE ☐ FEMALE

***DATE OF BIRTH** (MM/DD/YYYY) / /

☐ **ADD DEPENDENT**

QUALIFYING EVENT TYPE: ☐ Marriage ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other _____

*** DATE EVENT OCCURRED** / /

☐ **REMOVE DEPENDENT**

REMOVE DEPENDENT DUE TO: ☐ Divorce ☐ Death ☐ Entered Military Service ☐ Request

*** DATE EVENT OCCURRED** / /

☐ ADD HEALTH ☐ ADD DENTAL ☐ ADD BOTH

☐ REMOVE HEALTH ☐ REMOVE DENTAL ☐ REMOVE BOTH

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.
By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

DEPENDENT

*LAST NAME | *FIRST NAME

MAIDEN/MIDDLE NAME | SUFFIX (JUNIOR, SENIOR) | *SOCIAL SECURITY NUMBER ___ – ___ – ____

*RELATIONSHIP ☐ CHILD ☐ OTHER_____ | *GENDER ☐ MALE ☐ FEMALE | *DATE OF BIRTH (MM/DD/YYYY) __ / __ / ____

☐ ADD DEPENDENT | QUALIFYING EVENT TYPE: ☐ Marriage ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other _____ | * DATE EVENT OCCURRED __ / __ / ____

☐ REMOVE DEPENDENT | REMOVE DEPENDENT DUE TO: ☐ Divorce ☐ Death ☐ Entered Military Service ☐ Request | * DATE EVENT OCCURRED __ / __ / ____

☐ ADD HEALTH ☐ ADD DENTAL ☐ ADD BOTH | ☐ REMOVE HEALTH ☐ REMOVE DENTAL ☐ REMOVE BOTH

DEPENDENT

*LAST NAME | *FIRST NAME

MAIDEN/MIDDLE NAME | SUFFIX (JUNIOR, SENIOR) | *SOCIAL SECURITY NUMBER ___ – ___ – ____

*RELATIONSHIP ☐ CHILD ☐ OTHER_____ | *GENDER ☐ MALE ☐ FEMALE | *DATE OF BIRTH (MM/DD/YYYY) __ / __ / ____

☐ ADD DEPENDENT | QUALIFYING EVENT TYPE: ☐ Marriage ☐ Birth/Adoption ☐ Loss of Coverage ☐ Other _____ | * DATE EVENT OCCURRED __ / __ / ____

☐ REMOVE DEPENDENT | REMOVE DEPENDENT DUE TO: ☐ Divorce ☐ Death ☐ Entered Military Service ☐ Request | * DATE EVENT OCCURRED __ / __ / ____

☐ ADD HEALTH ☐ ADD DENTAL ☐ ADD BOTH | ☐ REMOVE HEALTH ☐ REMOVE DENTAL ☐ REMOVE BOTH

If any dependent child above is over the applicable maximum age under your Group Plan and is incapacitated, please contact your Group Administrator to determine if coverage is available and/or obtain additional documents for completion.

STUDENT EXTENSION CERTIFICATION: If the Group Plan under which you are applying requires student certification after age 26, please list any dependent child applying for student extension.

NAME OF CHILD		NAME OF SCHOOL	
NAME OF CHILD		NAME OF SCHOOL	

ELIGIBILITY: COORDINATION OF BENEFITS

For coordination of benefits purposes, will any person to be insured be covered under another health and/or dental plan or policy at the time this policy becomes effective? If yes, please provide the information below. Use additional paper if necessary.

NAME OF CONTRACT HOLDER/DEPENDENT | EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY) __ / __ / ____

NAME OF INSURANCE COMPANY | EMPLOYER'S NAME

POLICY, ID, CONTRACT OR CERTIFICATE NUMBER | GROUP NUMBER | TYPE COVERAGE ☐ SINGLE ☐ FAMILY

TRANSFER COVERAGE

A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete the information below.

If you have Individual coverage, please call Customer Service at **1-855-350-7441** to cancel your contract. If your Individual coverage is through the Federal Marketplace, please call the Marketplace at **1-800-318-2596** to cancel your contract.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

MEDICARE BENEFITS INFORMATION

*LAST NAME	*FIRST NAME

MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	MEDICARE NUMBER

PART A ◯	EFFECTIVE DATE (MM/DD/YYYY) / /	PART B ◯	EFFECTIVE DATE (MM/DD/YYYY) / /
PART C ◯	EFFECTIVE DATE (MM/DD/YYYY) / /	PART D ◯	EFFECTIVE DATE (MM/DD/YYYY) / /

TO BE COMPLETED BY EMPLOYEE

☐ **I waive my right to benefits and do not wish to enroll. Employer should maintain this record in employee's file.**

☐ I am requesting cancellation of my existing benefits as checked above.

☐ I apply for the Group Benefits Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group agent or Remitting Agent. I ask my Group to pay you directly and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application.

You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for services to me. I ask that my doctor, hospital or anyone else gives my or my family's medical records to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health and/or dental policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I acknowledge by my signature that I have read and understand the important information printed on the back of this application.

THE GROUP PLAN UNDER WHICH YOU ARE APPLYING FOR COVERAGE INCLUDES BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT OTHER THAN A CLAIM FOR BENEFITS UNDER SECTION 502(a) OF ERISA WILL BE SETTLED BY ARBITRATION — NOT A COURT. THE ARBITRATOR'S DECISION IS FINAL AND BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THIS DECISION CAN'T BE REVIEWED BY A COURT. THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE — AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE GROUP PLAN.

*SIGNATURE OF EMPLOYEE

DATE SIGNED (MM/DD/YYYY)	/ /	FULL-TIME EMPLOYMENT DATE (MM/DD/YYYY)	/ /

TO BE COMPLETED BY EMPLOYER

*EMPLOYER'S NAME	*GROUP NUMBER

EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
	– –

PRINTED GROUP ADMINISTRATOR NAME	GROUP ADMINISTRATOR EXTENSION

*GROUP ADMINISTRATOR'S SIGNATURE	DATE SIGNED (MM/DD/YYYY)
	/ /

IMPORTANT DISCLOSURE NOTICE

NOTICE OF GROUP HEALTH & DENTAL PLAN SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for health plan benefits for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards other coverage for you or your dependents). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or placement as an eligible foster child, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, placement for adoption, or placement as an eligible foster child.

If you or your dependent lose coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage, you may be able to enroll yourself and your dependent in this plan. You may also be able to enroll in this plan if you or your dependent become eligible for premium assistance under Medicaid or SCHIP for coverage under this plan. However, you must request enrollment within 60 days of any such event.

To request special enrollment or obtain more information, contact your employer at the telephone number or address listed for your employer in this enrollment application.

NOTICE OF GROUP DENTAL PLAN BENEFIT WAITING PERIODS

This dental plan includes benefit waiting periods that you may have to serve before certain benefits begin to be covered under this dental plan. Please refer to the section in your benefit booklet called "Benefit Waiting Periods."

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE FOR GROUP HEALTH PLANS

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Benefits for this will be subject to the same calendar year deductible and coinsurance provisions that apply to other medical and surgical benefits.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Applicant on behalf of itself and its members hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between Applicant and Blue Cross and Blue Shield of Alabama, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Alabama to use the Blue Cross and Blue Shield Service Marks in the State of Alabama, and that Blue Cross and Blue Shield of Alabama is not contracting as the agent of the Association. Applicant on behalf of itself and its members further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross and Blue Shield of Alabama and that no person, entity, or organization other than Blue Cross and Blue Shield of Alabama shall be held accountable or liable to Applicant for any of Blue Cross and Blue Shield of Alabama's obligations to Applicant created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Alabama other than those obligations created under other provisions of this agreement.

Benefits Enrollment Form

Please Complete And Return This Form To Your HR Administrator.

Employer Name _____ Hire Date _____

Step 1 - Tell us about yourself (Please enter your personal information.)

Full Name (First Middle Last) _____

Phone _____ Email _____

Gender _____ Date of Birth _____ Social Security Number _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip _____

Step 2 - Select your benefits (Enroll in a plan by placing an "X" in the corresponding box.)

Benefit Name	Enroll (X)	Enter Plan Name	Select Coverage Level/ Amount	
Dental Plan Guardian	☐	Plan Name:_____	☐ Select Coverage: Employee ☐ Employee + Child(ren)	☐ Employee + Spouse ☐ Family
Vision Plan VSP	☐	Plan Name: _____	☐ Select Coverage: Employee ☐ Employee + Child(ren)	☐ Employee + Spouse ☐ Family

Step 3 - Provide Family Information (We need this to enroll your dependents in the benefits you elected.)

Dependent Name	DOB	SSN	Relationship *Husband/Wife/Son/Daughter)*

Step 4 - Make it official (Please sign and return this form to your HR Administrator)

Employee Signature _____ Date _____

Employer Signature _____ Date _____

Alabama Pharmacy Association
1211 Carmichael Way
Montgomery, AL 36106-3672
(334) 271-4222 Fax: (334) 271-5423
www.aparx.org

Membership Application

Full Name: _____

Home Address: _____

City_____**County**_____**Zip**_____

Preferred Name:_____Gender_____

Date of Birth: _____

Name of spouse: _____

Mail To Go To: ☐Business or ☐Home

License # _____

NABP e-profile# _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Email: _____

Would you like to receive email updates from APA?

☐ Yes ☐No

Pharmacy School: _____

Graduation Year: _____

Type of degree: ☐BS ☐Pharm. D. ☐CPhT

Practice Setting

☐ Academia
☐ Certified Consultant
☐ Employee Pharmacist Chain
☐ Employee Pharmacist Independent
☐ Governmental
☐ Home Health/Infusion Independent
☐ Heath Plan/Managed Care
☐ Hospital
☐ Independent Owner
☐ Industry
☐ Long Term Care
☐ Nuclear
☐ Pharm Tech Chain
☐ Pharm Tech
☐ Relief Pharmacist

Academies

☐ Community (Chain)
☐ Compounding
☐ Health Systems
☐ Independent
☐ Long Term Care/Consultant
☐ Nuclear
☐Technician
☐ Student- School

Don't feel like filling all this out? Just scan this handy QR code!

SCAN ME

I can be a liaison to the following legislators in my District:

- U.S. Congressman _____
- State Representative _____
- State Senator _____
- APA Region _____

Business Name: _____

Business Address: _____

City_____**County**_____**Zip**_____

Business Phone: (_____)_____

FAX Number: (_____)_____

Membership Categories

☐ Active Member $250.00 (Licensed Pharmacist)
☐ Associate Member $150.00
(Has a business interest in the pharmacy profession, but not a licensed pharmacist)
☐ Spouse Member Non-Pharmacist $75.00
☐ Resident Member $50.00
☐ First Year Pharmacist $50.00
(First Year of practicing pharmacy)
☐ Retired Pharmacist $50.00
☐ Pharmacy Technician $25.00
☐ Pharmacy Student $20.00

Optional Association Support

$ _____ APA-PAC
$ _____ APA Scholarship Fund
$ _____ APA Building Fund
$ _____ APA Research and Education Foundation

☐ Check Enclosed: Total Amount $_____

☐ Charge $_____ to my:

☐ Visa ☐ MasterCard ☐ Am. Express ☐ Discover

_____
Card No. Exp. Date

_____
Signature

_____3-Digit Security Code_____

Name on card if different from above:

Billing Address: _____

City_____County_____Zip_____

The Tax Cuts and Jobs Act of 2018 removed the option of deducting membership dues paid by individuals to the APA. However, businesses paying for employee memberships may deduct 81% of dues. ***Effective 1/1/23***

RECRUITED BY: _____

PLEASE MAKE A COPY FOR YOUR RECORDS AND MAIL TO:
APA, 1211 CARMICHAEL WAY, MONTGOMERY, AL 36106-3672