

PATIENT INFORMATION				Please remember that your program eligibility requires that you promptly notify the Compassionate Care Program by calling (855) 541-5926 if you become insured by any private or government insurance plan			
FIRST NAME			LAST NAME			MI	
DATE OF BIRTH		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		By providing your e-mail address, you consent to receive additional mailings from the Compassionate Care Program. E-MAIL			
HOME PHONE			MOBILE PHONE				
MAILING ADDRESS			CITY		STATE		ZIP CODE
PREFERRED METHOD OF CONTACT <input type="checkbox"/> Home phone <input type="checkbox"/> Mobile phone <input type="checkbox"/> Mail <input type="checkbox"/> E-mail					COUNTRY		
Please indicate if you or your partner are active duty US Military: <input type="checkbox"/> Yes (Indicate branch): _____ <input type="checkbox"/> No							
Please indicate if you or your partner are a retired member of the US Military: <input type="checkbox"/> Yes (Indicate branch): _____ <input type="checkbox"/> No							
If you are a retired member of the US Military, please attach a copy of your DD-214							
If you're unavailable when we call, is it OK for us to leave a message, including the Compassionate Care Program name? <input type="checkbox"/> Yes <input type="checkbox"/> No							

TREATMENT	
Are you currently undergoing fertility treatment with a fertility specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your physician diagnosed you as requiring assisted reproductive technologies (such as IVF)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever received products through the Compassionate Care Program in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I have been prescribed the following: <input type="checkbox"/> Any Gonal-f® (follitropin alfa for injection) product <input type="checkbox"/> Cetrotide® (cetrotorelix acetate for injection)	
<input type="checkbox"/> Ovidrel® PreFilled Syringe (choriogonadotropin alfa injection)	

FAX, MAIL, OR E-MAIL YOUR INCOME VERIFICATION FORM TO:	
Fax: (919) 415-2870 Mail: The Compassionate Care Program • 6501 Weston Parkway, Suite 370 • Cary, NC 27513 E-mail: enrollments@emdcompassionatecare.com	
We will need to know the annual adjusted income for the entire household. The following are acceptable income documents that we can use to validate your income:	
<input type="checkbox"/> 1040 Form	<input type="checkbox"/> 1040 Form Married Filing Separately (MFS) (Need a form from both filers)
<input type="checkbox"/> 1040A Form	<input type="checkbox"/> 1040A Form (MFS)
<input type="checkbox"/> 1040EZ Form	<input type="checkbox"/> W2/1099R Form
<input type="checkbox"/> 1099 Form	<input type="checkbox"/> Pension Notification Letter
<input type="checkbox"/> Social Security Award Letter	
How many people live in your household?	

PATIENT SIGNATURE AND AUTHORIZATION:		
Fax: (919) 415-2870 Mail: Compassionate Care Program • 6501 Weston Parkway, Suite 370 • Cary, NC 27513		
My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge and that I have read, understand, and agree to the terms of this enrollment form and the attached Authorization to Use and Disclose Health and Other Personal Information form. I commit to making the Compassionate Care Program aware, if at any time, I gain insurance coverage for infertility treatment. No units of product received under this program will be submitted for Medicare, Medicaid, TRICARE, the Department of Veterans Affairs, the Department of Defense, or any public or private third-party reimbursement, or returned for credit.		
Please remember that your program eligibility requires that you promptly notify the Compassionate Care Program by calling (855) 541-5926 if you become insured by any private or government insurance plan.		
PATIENT SIGNATURE	PATIENT NAME	DATE

ART CENTER CONTACT OR SITE NAME:	
If applicable, please provide an e-mail address for the person who manages the Compassionate Care Program at your ART Center.	
ART CENTER	CONTACT E-MAIL
For assistance or additional information, call (855) 541-5926 Monday to Friday, 8:00 AM to 8:00 PM EST	

Authorization to Use and Disclose Health and Other Personal Information

Patient's Name _____

Address _____

Home Phone _____ DOB ____/____/____

I authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to EMD Serono, Inc. and its agents and representatives including any company that helps administer EMD Serono's Compassionate Care Program (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

- (1) contact me by mail, e-mail, and/or telephone to enroll me in, and administer EMD Serono's Compassionate Care Program;
- (2) provide me with materials relating to EMD Serono's Compassionate Care Program;
- (3) verify the accuracy of the information I provide and in my application for EMD Serono's Compassionate Care Program;
- (4) conduct surveys to measure my satisfaction with EMD Serono's Compassionate Care Program.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, there is no guarantee that it will not be disclosed to another third party. However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

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PATIENT MUST SIGN THE BACK OF THIS FORM THEN SEND OR FAX BOTH PAGES

Website Enrollment Form

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive EMD Serono Products, but it will limit my ability to participate in EMD Serono's Compassionate Care Program.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono or its representatives in writing by mail or fax at 6501 Weston Parkway, Suite 370, Cary, NC 27513, fax (919) 415-2870. If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): _____

Signature of patient (or personal representative): _____ Date: ___/___/_____

Authority/relationship of personal representative (if applicable): _____

Signature of patient (or personal representative): _____ Date: ___/___/_____

Authority/relationship of personal representative (if applicable): _____