

HEALTH ISSUES THAT ARE OF INTEREST TO YOU. Please check all that apply.

<input type="checkbox"/> Acne	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Mouth/Throat Problems, Long Term
<input type="checkbox"/> Alcohol Dependence	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Muscular/Neuromuscular Problems
<input type="checkbox"/> Allergy	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Obesity
<input type="checkbox"/> Anemia	<input type="checkbox"/> Erectile Dysfunction (ED)	<input type="checkbox"/> Osteopenia
<input type="checkbox"/> Angina	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fibroid Cysts	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Peripheral Vascular Disease (PVD)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gastrointestinal Problem	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Prostate condition, BPH
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Gout	<input type="checkbox"/> Psychoses
<input type="checkbox"/> Blood Clotting Disorders	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Pulmonary Diseases / COPD
<input type="checkbox"/> Blood Dyscrasias	<input type="checkbox"/> Heart Arrhythmias	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Blood Pressure, High	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Shingles Sleep Disorders
<input type="checkbox"/> Blood Pressure, Low	<input type="checkbox"/> Heart Failure, Congestive	<input type="checkbox"/> Sleep Disorders
<input type="checkbox"/> Breast Feeding	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Thyroid, Overactive
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Thyroid, Underactive
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> Ulcerative Colitis Ulcers
<input type="checkbox"/> Dementia	<input type="checkbox"/> Liver Disorders	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Depression	<input type="checkbox"/> Lupus Erythematosus	<input type="checkbox"/> Upper Respiratory Problems
<input type="checkbox"/> Depression, Manic	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Dermatologic Disorders	<input type="checkbox"/> Menopause	<input type="checkbox"/> Weight Over
<input type="checkbox"/> Diabetes, Type 1	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Weight Under
<input type="checkbox"/> Diabetes, Type 2	<input type="checkbox"/> Mitral Valve Disease	<input type="checkbox"/> Ear Infection, Long Term
<input type="checkbox"/> Other(please specify): _____		

PAIN RELIEVERS, VITAMINS OR HERBAL SUPPLEMENTS THAT ARE OF INTEREST TO YOU

<input type="checkbox"/> ACETAMINOPHEN (i.e., TYLENOL®)	<input type="checkbox"/> GINKGO BILOBA	<input type="checkbox"/> NAPROXEN (i.e., ALEVE®)
<input type="checkbox"/> ASPIRIN (i.e., BAYER®)	<input type="checkbox"/> GINSENG	<input type="checkbox"/> ST. JOHN'S WORT
<input type="checkbox"/> CALCIUM	<input type="checkbox"/> IBUPROFEN (i.e., ADVIL®)	<input type="checkbox"/> VITAMIN B
<input type="checkbox"/> ECHINACEA	<input type="checkbox"/> IRON SUPPLEMENT	<input type="checkbox"/> VITAMIN C
<input type="checkbox"/> GARLIC	<input type="checkbox"/> MULTI-VITAMIN	<input type="checkbox"/> VITAMIN E
<input type="checkbox"/> OTHER (Please Specify) _____		

Please check all that apply (optional):

<input type="checkbox"/> I have cat(s)	<input type="checkbox"/> I have dog(s)	<input type="checkbox"/> I am a smoker	<input type="checkbox"/> I have sensitive teeth
<input type="checkbox"/> I have dentures	<input type="checkbox"/> I have a newborn 0-12 mos.	<input type="checkbox"/> I have a toddler 1-5yrs. old	

Member Signature (all members must sign): _____ Date: _____

Member Name (Please Print): _____ Type of ID given: _____

If under 18 years old.

Personal Representative's Name _____

Relationship to Customer _____

I understand that I may revoke this Authorization in writing at any time by sending a letter to The Great Atlantic & Pacific Tea Company 2 Paragon Drive Montvale, NJ 07645 Attn: Sr. Director of Pharmacy, except to the extent that the Pharmacy has taken action in reliance on its authorization. The enrollment fee is non-refundable. **This Authorization ends on December 31, 2008 unless otherwise designated.**

I authorize (Personal Representative's Name) _____, (Relationship to Customer) _____, to use my bonus card and receive information on my behalf.

Family Member Signature: _____ Date: _____