REWARDS Card Program Enrollment Form

Please complete this enrollment form and present it to any employee at one of the participating Guardian Pharmacies indicated on the attached card.

Please select one only:

◯ I am a new applicant ◯ I am changing my personal information

◯ I am requesting a replacement card

My old card number is (if known): _____

Please select one: ◯ Miss ◯ Ms. ◯ Mrs. ◯ Mr. ◯ Dr.

Please select gender: ◯ Male ◯ Female

First Name: _____ Middle Initials: _____

Last Name: _____ Date of Birth: _____
YYYY/MM/DD

Address: _____ Apt #: _____

City/Town: _____ Prov.: _____ Postal Code _____

Home Telephone: _____ Mobile Telephone: _____

E-mail Address: _____

Do you have any children living in your household? ◯ Yes ◯ No

All information provided by you and any information that we gather as a result of your purchases is kept in the strictest confidence. **The information which you supply or which we gather will not be sold, given or supplied to anyone outside Drug Trading.** By signing this Enrollment Form you signify your acceptance of the terms and conditions of the Guardian Rewards Program.

◯ Would you like us to contact you for future offers etc.? ◯ By Mail ◯ Email ◯ Text Message

Customer's Signature: _____ Date: _____
YYYY/MM/DD