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EXHIBIT B – Provider Registration Declaration

ESC Provider Number(s):

Effective Date:

Type of Request, please check all of those that apply:

- ☐ New opening
- ☐ Change in ownership
  - ☐ Change in legal business name
  - ☐ Change in owners (directors, officers), i.e., adding or removing of an owner(s) or director(s)
  - ☐ Amalgamation of companies
- ☐ Set up Electronic Funds Transfer (EFT) or change to EFT (electronic funds transfer)/ direct deposit/ bank account information
- ☐ Change in pharmacy operating address
- ☐ Change in pharmacy operating name
- ☐ Change in pharmacy dispensing fee
- ☐ Other: specify: ____

Documents that must be submitted:

- ☐ Incorporation documents that list the names of all owners of the company
- ☐ Copies of government issued ID's for all owners of the pharmacy and the pharmacy manager
- ☐ Certificate of liability insurance (if the request is for a new opening or change in ownership)
- ☐ Void cheque with legal business name clearly stated on the cheque
- ☐ Proof of pharmacy accreditation from provincial pharmacy regulatory body
- ☐ All pages of Exhibit B (write N/A on blank pages)
- ☐ A list of all additionally owned pharmacies by all owners listed must be included. This can be added on the Exhibit B itself or provided on a separate sheet if there are multiple pharmacies to list. The list must include the ESC provider number, operating name, complete pharmacy operating address.

SECTION A: Provider Legal Business Information

Type of Business ☐ Corporation ☐ Sole Proprietorship ☐ Partnership	Legal Business Name *(must match Provider's governance documents (Articles of Inc., Partnership Agreement, etc.), a copy of which you are required to submit with this Agreement.* ***Failure to provide all applicable documents may cause delays of this application and/or its denial.)***	
Legal Business Registered Office Address		
City	Province	Postal Code
Telephone	Fax	Email

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Owners, Officers and Directors of the Company (attach a separate sheet if necessary):

*Please list all ESC Provider numbers where an owner, officer or director has ownership in any additional pharmacies). If more than six owners, officers and/or directors, please print and attach additional copies of this page. *If applicable*

1 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

2 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

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Owners, Officers and Directors of the Company – *continued* (attach a separate sheet if necessary):

3 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

4 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

5 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

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Owners, Officers and Directors of the Company – *continued* (attach a separate sheet if necessary):

6 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

Have any of the Owners, Officers, Directors or Pharmacists listed above ever applied and been denied an ESC or Eclipse Provider Number? ☐ No ☐ Yes →Name(s):
Details

Have any of the Owners, Officers, Directors or Pharmacists listed above had an ESC or Eclipse Provider Number and lost billing privileges? ☐ No ☐ Yes →Name(s):
Details

Do any of the Owners, Officers, Directors or Pharmacists listed above have any pending concerns at their respective regulatory body(ies)? ☐ No ☐ Yes →Name(s):
Details

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SECTION B: Pharmacy Information

(If registering more than one pharmacy under the same provider legal business name, make additional copies of section B)

Language ☐ English ☐ French	ESC Provider Number	Pharmacy License/ Accreditation Number
Pharmacy Operating Name	Banner/ Chain Name	
Pharmacy Address		
City	Province	Postal Code
Pharmacy Telephone	Pharmacy Fax	Pharmacy Email
Pharmacy Commercial General Liability Insurance *(include certificate for general commercial liability insurance, including minimum coverage amount. See Section 4.A. of the Agreement)*	Usual and Customary Professional Fee $	Ontario ONLY: Ontario Drug Benefit (ODB) Dispensing Fee $
Pharmacy Manager Name *(first and last)*		
Pharmacy Manager's Registration License Number *	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*	

If purchasing an existing business, please indicate the following:

Existing Legal Business Name		
Existing Operating Name		
Existing Address		
City	Province	Postal Code
Existing Telephone	Existing Fax	Existing Email
Existing Provider Number		

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Payment Information – Electronic Funds Transfer (EFT):

I instruct ESC to set up or change my direct EFT payments. This form authorizes deposits to the bank account and does not authorize withdrawals or any other transactions with respect to the bank account. All information will be treated as PRIVATE AND CONFIDENTIAL. I will advise ESC promptly of any changes to the bank, branch or account number.

<table>
<tr><td colspan="4">Banking Information
Attach: ☐ VOID Cheque OR ☐ Official Bank Letter
A copy of a pre-printed VOID cheque or Official Bank Letter is required. Corporate details must be included on either the VOID Cheque or Official Bank Letter. If the attached cheque is not pre-printed with the pharmacy's legal and/or operating name, please provide a letter signed by an officer of your bank, indicating the account number and certifying you as the account holder.</td></tr>
<tr><td colspan="4">Account Holder Name</td></tr>
<tr><td colspan="2">Bank Name</td><td colspan="2">Branch Name (if applicable)</td></tr>
<tr><td colspan="4">Branch Address</td></tr>
<tr><td colspan="2">City</td><td>Province</td><td>Postal Code</td></tr>
<tr><td>Institution No. / Bank Code</td><td>Branch/ Transit No.</td><td colspan="2">Account No.</td></tr>
</table>

Pharmacy Software Vendor Information (EDI Claims Submission):

Name of Vendor

Acknowledgment and Agreement

By signing this declaration, I am aware that the information provided may be validated and audited by ESC at any time, and that any change in the original declaration requires a re-application by the provider. Providers shall notify ESC in writing of any change or adjustment to information above twenty (20) business days in advance of such change.

<u>All supporting documents and pages of this form must be returned by:</u>
Fax to 1 855 622-0669 or
Mail: Express Scripts Canada
Attention: Provider Relations
5770 Hurontario St 10th Floor
Mississauga, ON L5R 3G5

Completed by:

Signature, Owner or Director of Business (no stamps)	Printed Full Name of the Owner or Director of Business
Contact Telephone Number of the Owner or Director	Date Signed *(mm/dd/yyyy)*