EndeavorRx By AKILI

Patient Assistance Program Application

Thank you for your interest in the Patient Assistance & Support Program for the EndeavorRx® treatment application. If you are having trouble affording your prescription, this program is designed for you.

The type of assistance available varies based on certain criteria that will be explained to you, including but not limited to your household income and your insurance status. To receive assistance from this Patient Assistance & Support Program, you must complete and submit this application form in its entirety and meet program eligibility requirements. We have included a checklist at the bottom of this page to guide you through completing and submitting your application.

If you have any questions, please call the program at 1-855-977-0975 Option 3. We are available to answer your calls Monday through Friday, from 9 AM to 9 PM Eastern Time.

Please note: Submission of a complete application form does not guarantee enrollment in the program. Each application will be considered on a case-by-case basis.

Application Checklist

Please ensure all items on the list are completed and attached, or the application may be delayed.

- ○ Fill out your personal information in Section 1
- ○ Fill out your financial information in Section 2
- ○ If you have health insurance: fill out the insurance information in Section 3 and attach a copy of your insurance card
- ○ Sign and date the application in Sections 4, 5, and 6 (Please note, we are unable to process your application without your authorization and consents as required in Sections 4, 5, and 6)
- ○ When you have completed your form, please send to us via email or fax using the contact information at the bottom of this page. Incomplete or incorrect information may delay the processing of your application, so please ensure that all information is provided correctly and that all signatures are obtained.

Patient Assistance Program Application

Send completed and signed forms to: Fax: 888-975-0603 or Email: help@usephil.com

Section 1: Patient Personal Information

Patient Name: _____

Gender: ○ Male ○ Female ○ Other ○ Prefer Not to Say **DOB:** ____ /____ /____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parent / Legal Guardian Name: _____ **Relationship to Patient:** _____

Parent / Legal Guardian Phone: _____ **Parent / Legal Guardian Email:** _____

Parent / Legal Guardian Social Security Number: _____

Section 2: Parent / Legal Guardian Financial Information

Number of people in your household: **Adults =** _____ **Children =** _____

Total combined income for you, your spouse, and your dependents: $ _____ Annually

Section 3: Insurance Information

What type of insurance coverage covers the patient named on the prescription? (Check all that apply)

○ **Medicare Part A** ○ **Medicare Part B** ○ **Medicare Part D** ○ **Medicare Advantage**

○ **Medicare Aid** ○ **State Pharmacy** ○ **Other** _____ ○ **None**

For each policy you have that provides coverage for the patient, please attach a copy of both sides of your insurance card and fill in the following:

Primary Insurance

Insurance Plan: _____

Phone Number: _____

Name of Policy Holder: _____

Policy Holder DOB: _____

Policy ID: _____

Group Number: _____

Plan Type: _____

Secondary Insurance

Insurance Plan: _____

Phone Number: _____

Name of Policy Holder: _____

Policy Holder DOB: _____

Policy ID: _____

Group Number: _____

Plan Type: _____

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Section 4: Privacy Authorization

This Patient Assistance Program ("PAP") is sponsored by Akili Interactive Labs, Inc. ("Akili"), the manufacturer of the EndeavorRx™ application. Before I may receive assistance from the PAP, I understand that the company Phil, Inc. as the administrator of the PAP, as well as Phil, Inc.'s contractors, agents or other representatives, will need to obtain, review, use, and disclose my and/or my child's (the patient named in this application above) personal health information, including information relating to the patient's medical condition and prescription medications and the information included in and submitted throughout this PAP application process (together, the "PHI"). I therefore authorize each of my physicians, pharmacies, and health plans to disclose PHI, as necessary, to (i) the administrators of the PAP and their respective contractors, agents and representatives, in order to verify our eligibility to enroll in the PAP and to enroll us in the PAP if we are eligible; and (ii) the administrators of the PAP and their respective contractors, agents, and representatives to investigate insurance coverage in connection with the PAP. I also authorize the administrators of the PAP, and their respective contractors, agents or representatives to (i) use PHI to provide the services described in this patient application form, including to communicate with me by U.S. postal mail, telephone, text, or e-mail and to prepare summaries that do not include PHI for statistical purposes; and (ii) share PHI with one another and with my physicians and pharmacists as well as with Medicare, my health plans, and their administrators, agents, contractors, or representatives, in order for them to coordinate my benefits and investigate my insurance coverage. I also authorize the administrators of the PAP and their respective contractors, agents, representatives, and third-party service partners to disclose PHI to authorized representatives of Akili as necessary to ensure compliance with the rules of the PAP. I also authorize Akili's authorized representatives to use PHI to communicate with the administrators of the PAP, their respective contractors, agents, representatives or third-party service partners, my physicians, pharmacies, and me for compliance purposes. I understand that PHI disclosed pursuant to this authorization, once disclosed, may not be governed by federal privacy law and may be subject to re-disclosure. I further understand that if I choose not to provide this authorization, it will not affect my eligibility for, or receipt of, treatment, including with Akili products, or health care insurance benefits, but that I will not be able to receive any assistance from the PAP. I understand that I may cancel this authorization at any time by telephoning Phil, Inc. at 855-977-0975 or by mailing a written request for cancellation to Phil Inc., 234 Front Street, 4th Floor, San Francisco, CA 94111. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as the PAP, its administrators, and their respective contractors, agents and representatives, may no longer rely on the authorization to use or disclose PHI, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation. I understand that if I do not cancel this authorization, the authorization will expire fifteen (15) months from the date of signature (or the maximum period allowed by applicable state law, if less than fifteen (15) months). The administrators of the PAP will retain the information I have submitted in accordance with Phil Inc.'s and Akili's records retention policies. I understand that I am entitled to receive a copy of this authorization once it has been signed.

By signing, I certify that I have read and agree to the above Patient Privacy Authorization

Patient Name: _____

Name of Patient's Parent or Legal Guardian (Print): _____

Relationship to Patient: _____

Parent / Legal Guardian Signature: _____ **Date:** _____

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Section 5: Parent or Legal Guardian Certification

I certify that all of the information provided in this application form, including information about household income, is complete and accurate. I understand that Patient Assistance Program ("PAP") assistance will terminate if the PAP becomes aware of any fraud or if the treatment which is the subject of this patient application form is no longer prescribed for my child named on this application. I understand that completing this application does not ensure that I will qualify for assistance. I certify that I will not seek reimbursement or credit for any prescription which is the subject of this application form from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have the prescription which is the subject of this patient application form, or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that if I qualify for free treatment, it will be for the remainder of the current calendar year and should I require assistance in future years, I must reapply for PAP assistance. I understand that PAP reserves the right to modify this application form, modify or discontinue the PAP, or terminate assistance at any time and without notice. I authorize the PAP and its affiliates to forward the prescription which is the subject of this patient application form to a dispensing pharmacy on my behalf. PAP is not responsible for verifying any information contained in the prescription forwarded as part of the enrollment process, including, without limitation, allergies, medical conditions, or other medications being taken by me. I understand that I will notify the PAP immediately if anything changes with my prescription, income or my insurance coverage. I understand that the PAP reserves the right to request documentation to verify the information provided in this application for purposes of determining my eligibility for assistance, and to conduct periodic audits of my enrollment, including the physician who will be supervising my treatment, to verify the information provided herein. I understand that I may opt out of receiving the PAP assistance by notifying the PAP at 855-977-0975 understand that assistance received through the PAP is not insurance.

By signing, I certify that I have read and agree to the above Patient Certification and the terms and conditions of the Patient Assistance Program. By signing, I also certify that all information that I have provided in this application is complete and accurate.

Patient Name: _____

Name of Patient's Parent or Legal Guardian (Print): _____

Relationship to Patient: _____

Parent / Legal Guardian Signature: _____ **Date:** _____

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Section 6: Fair Credit Reporting Act Authorization

I understand that I am providing 'written instructions' to Phil, Inc. under the Fair Credit Reporting Act authorizing Phil, Inc. to obtain information from my credit profile or other information from Experian Health and/or Experian Information Solutions, Inc. I authorize Phil, Inc. to obtain such information solely to verify annual income for the purposes of patient assistance qualification.

Patient Name: _____

Name of Patient's Parent or Legal Guardian (Print): _____

Relationship to Patient: _____

Parent / Legal Guardian Signature: _____ **Date:** _____