PRIME THERAPEUTICS®

Agent Authorization Form

If you would like to designate an authorized agent to make a request, on your behalf, to exercise your rights under applicable State Privacy Law, please complete ALL fields on BOTH pages of this form, including the date and your signature. You may either email the completed form to Privacy@PrimeTherapeutics.com or mail it to: ______________________________
Prime Therapeutics LLC, Attn: Privacy Officer, P.O. Box 64812, St. Paul, MN 55164-0812.

If you don't complete ALL fields in this form, Prime Therapeutics may reject your request.

Consumer Information:

Name ____
(Last, First and Middle Initial)

Street Address ____

City, State ____

ZIP Code ____

Email ____

Phone ____

Authorized Agent Information:

Name ____
(Last, First and Middle Initial)

Street Address ____

City, State ____

ZIP Code ____

Email ____

Phone ____

Continued

I designate the Authorized Agent listed above to make the following request(s), on my behalf, pursuant to applicable State Privacy Law:

- ☐ Right to Know. Right to confirm that we have collected personal information about you and know what personal information we collected about you.
- ☐ Right to Access. Right to access a copy of the specific pieces of personal information we collected about you.
- ☐ Right to Delete. Right to request deletion of the personal information we collected about you.
- ☐ Right to Correct. Right to correct the inaccurate personal information we collected about you.

I agree that my Authorization is effective for one year from the date of execution of this Authorization (the "Execution Date"), unless an earlier termination date is provided below.

Please list the termination date of the Authorization, if this Authorization expires earlier than one year from the Execution Date. Termination Date: ___________________________________.

I understand that I have the right to terminate this Authorization at any time for any reason by submitting a written request to Prime Therapeutics at Privacy@PrimeTherapeutics.com or by mail at:
Prime Therapeutics LLC, Attn: Privacy Officer, P.O. Box 64812, St. Paul, MN 55164-0812

By submitting this form, I affirm that I am the Consumer whose name appears above and that the information provided in this form is true and accurate. I authorize the Authorized Agent to submit the requests indicated above to Prime Therapeutics on my behalf and authorize Prime Therapeutics to process such requests, which will be processed in accordance with applicable laws and Prime Therapeutics' Privacy Policy available at https://www.primetherapeutics.com/privacy-policy/.

Date ___________________________________

Consumer's Signature ___________________________________

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