PRIME THERAPEUTICS®

CCPA Agent Authorization Form

If you are a resident of California and would like to designate an authorized agent to make a request, on your behalf, to exercise your rights under the California Consumer Protection Act (CCPA), 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 the California Consumer Protection Act:

- ☐ Right to information relating to the categories of personal information we collected about the consumer in the past 12 months
- ☐ Right to have us identify the specific pieces of personal information we collected about the consumer in the past 12 months
- ☐ Right to request a copy of the specific pieces of personal information we collected about the consumer in the past 12 months
- ☐ Right to request deletion of the personal information we collected from the consumer

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 Notice for California Residents.

Date _________________________________

Consumer’s Signature ____________________________________

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