

**NBN/RX  
UTAH AGC-TEAMSTERS WELFARE TRUST  
MAIL ORDER PHARMACY PLAN**

- Complete a separate envelope for each person for whom you are ordering.**
- For NEW PRESCRIPTIONS**, complete all information except the Rx number column.
- For REFILLS**, complete all information.
- Use the co-payment calculation sections of this envelope to determine the amount of money to send. If there is a question on how much to send with a new prescription, please send the Brand Name Co-payment, and you will be reimbursed the difference if Generic is available; or billed if it is a Non-Formulary Brand.
- Enclose these items for each person in the pre-addressed envelope:
  - The doctor's prescription if not a refill.
  - A check made payable to Union Center Pharmacy for the co-payment if you are paying by check. **DO NOT SEND CASH!**
- Stamp and mail the envelope. Allow 14 days for delivery.

**If you have any questions concerning your order, please call 1-800-441-9174.**  
Only refills may be ordered by phone or fax with a Visa or MasterCard or at [www.unioncenterpharmacy.com](http://www.unioncenterpharmacy.com)  
Fax 206-448-4406

CO-PAYMENT CALCULATION		
Plan	Brand Drug Co-Payment	Generic Drug Co-Payment
Retirees Non-Medicare	\$40	\$0
Retirees Medicare	\$40	\$0
Active Plan	\$40	\$0

Clearly Print All Information	Participant Name		Participant Social Security Number	
	Street Address <input type="checkbox"/> new address		Phone Number (     )     )	
On Refill Orders, Please Print Prescription Number(s) On Lines Below ↓	City and State		Zip	
	Patient's Name		Doctor's Name	
Rx Number	Type	Name of Drug	Strength	Quantity
	<input type="checkbox"/> New <input type="checkbox"/> Refill			
	<input type="checkbox"/> New <input type="checkbox"/> Refill			
	<input type="checkbox"/> New <input type="checkbox"/> Refill			
	<input type="checkbox"/> New <input type="checkbox"/> Refill			
I wish to pay the total due by:		Is medication for work-related condition?		
<input type="checkbox"/> Check <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard		<input type="checkbox"/> Yes <input type="checkbox"/> No		
I Certify the information given here is correct and authorize release of any information needed by the Plan Administrator and Company:		Medication is for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
Participant's Signature		Patient's Date of Birth		
Child Resistant Cap? <input type="checkbox"/> Yes <input type="checkbox"/> No		If patient is allergic or sensitive to any drug, list here:		
Visa or Mastercard No.     Exp. Date		Is medication for work-related condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Co-Payment Calculation:</b> # of generic Rx's     x \$     =     (Total) # of brand name Rx's     x \$     =     (Total) <b>DO NOT SEND CASH</b>				