

**RESTAT-UNION CENTER PHARMACY  
UTAH-IDAHO TEAMSTERS SECURITY FUND • MAIL ORDER PRESCRIPTION DRUG 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 refunded 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**

<u>Plan Co-payment</u>	<u>Brand Drug</u>	<u>Generic Drug</u>
All Active Plans (other than the UPS Plan)	\$30.00	No CO-Pay
Retiree Medicare	\$50.00	\$20.00
Retiree Non-Medicare	\$50.00	\$20.00

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