ORDER FORM

Please tear at perforation and place in envelope

TO SEND ORDERS:

- Fill out the requested information below completely. Please include a phone number so we can contact you if we have any questions about your order.
- Make sure you use the participant's member ID number.
- Be sure to include your doctor's name and phone number for each prescription on the order form.
- Place your prescription(s) or Tel-Drug's refill request inside the envelope. If this is your first order, you should also fill out your Patient Profile (on the other side of the form).

A pharmacist is available during normal business hours to answer questions concerning your prescription.

Un farmacéutico está disponible durante horas hàbiles para responder a las preguntas que tenga sobre sus recetas.

FOR HELP WITH PLACING YOUR ORDER, CALL: 1-800-TEL-DRUG (835-3784) OR E-MAIL WWW.TELDRUG.COM

PARTICIPANT INFORMATION

Participant's Name		Participant's Member ID #
Mail to Address		
City	State	Zip
E-Mail Address		
Work Phone ( )	Home Phone ( )	
Company Name		

PAYMENT INFORMATION

❑ I have enclosed my check or money order, made payable to Tel-Drug, Inc.

❑ Please bill my credit card. ❑ Amex ❑ Visa ❑ MasterCard

Card Number	Expiration Date /
Cardholder's Signature	
Number of Prescriptions	Total Amount Enclosed
Participant's Signature	Date / /

PRESCRIPTION INFORMATION

PATIENT'S NAME	BIRTHDATE	SEX	PATIENT IS:			DOCTOR'S NAME & PHONE NO.
			SELF	SPOUSE	OTHER	

I represent that the information on this form is correct. I understand that generic drugs will be dispensed in all cases where legally permissible and medically appropriate, unless this box is checked ❑. If this box is checked, a higher copayment amount may apply.

Tel-Drug Rx® is a registered service mark of CIGNA Corporation. Tel-Drug Rx® refers to a program insured and/or administered by Connecticut General Life Insurance Company. Tel-Drug, Inc. is a subsidiary of CIGNA Corporation.

❑ Check here if information has changed.

PATIENT PROFILE

Please Complete With Your First Order, Or As Information Changes

Please complete this form for ***ALL*** eligible family members participating with ***Tel-Drug*** and send it in with your ***first*** order. There is no need to complete this form with subsequent orders unless the information changes. This information will be used to check for potential drug interactions. Just check the appropriate boxes for each covered family member. Any other allergies should be described.

PRINT OR TYPE
Include last names if not the same as participant's

			ALLERGIES					HEALTH CONDITIONS					
	Date of Birth	Sex	None	Aspirin	Penicillin	Codeine	Sulfa	Thyroid	Diabetes	Glaucoma	Heart Condition	High Blood Pressure	Lung Condition
Participant's Name													
Eligible Spouse's Name													
Other Eligible Dependent's Name													
Other Eligible Dependent's Name													
Other Eligible Dependent's Name													

Other Allergies ______________________________

Other Health Conditions ______________________________

I represent that the information on this form is correct, and authorize release of all information regarding my or my family's medical and prescription drug history and treatment to the Plan Sponsor and to Tel-Drug, Inc.

Signature ______________________ Date ______________