



UNITED FEDERATION OF TEACHERS WELFARE FUND DIRECT ACCESS RX PLAN

UFT Member ID - Please Print the Following Information

LAST NAME

FIRST

SOCIAL
SECURITY #

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Enrollment - Please Print the Following Information

LAST NAME _____

FIRST NAME _____ DOB ____ / ____ / ____

SOCIAL SEC. # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK PHONE () _____ HOME PHONE () _____

RELATIONSHIP TO UFT MEMBER: SELF SON, DAUGHTER PARENT(S) SPOUSE/DOMESTIC PARTNER

SUBSCRIPTION: INDIVIDUAL FAMILY (LIST ALL ELIGIBLE FAMILY MEMBERS)*

LIST DEPENDENTS IF ON FAMILY PLAN

RELATIONSHIP

DATE OF BIRTH

LIST DEPENDENTS IF ON FAMILY PLAN	RELATIONSHIP	DATE OF BIRTH
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Unmarried dependent children age 19, who are no longer in full-time student status, dependent students beyond age 23, and parents require individual subscriptions.*

Enclosed is a check (payable to Express Scripts, Inc.) in the amount of: \$21.00 \$45.00
P.O. BOX 390028, Bloomington, MN 55439 ATTN: UFT DIRECT ACCESS PLAN

CARD NUMBER _____ EXPIRATION DATE _____

SIGNATURE _____