

Prescription Drugs Advance Purchase Form

PLEASE FAX COMPLETED FORM TO: (802) 846-2702



Employer's Name: Middlebury College

Group Number: 50643

Employee's Name: _____ Participant Number: _____

Work Phone: (____) _____ Home Phone: (____) _____

Email address: _____

Extended Absence Dates - Departure Date: _____ Return Date: _____

Extended Absence Location: _____

Reason for Advance Purchase Vacation Y N Sabbatical/Extended Absence Y N

Prescription(s) Information:

Refill Y N New Script Y N

Patient Name/DOB *Drug Information* (name, strength, dosage, directions) *Prescribing Physician Name*

Participating Pharmacy Name: _____

Participating Pharmacy Address: _____ *Phone:* (____) _____

Participant Authorization

I am an employee of the Middlebury College Health Plan and the employee identified above and signed below. I hereby certify that coverage will be maintained via payroll deductions for all family members requesting advance prescriptions for the entire period of the extended absence. If, for any reason, I discontinue my coverage or coverage for my dependent(s) during the extended absence or if employment with Middlebury College is terminated, I acknowledge that I will be responsible for repaying the cost of the benefits and services advanced for me and/or my family members.

Signature of Employee: _____ Date: _____

Employer Authorization (Sabbatical or other Extended Absence)

I am the undersigned Employer Representative. I hereby certify that the above-named employee will be on extended absence for the period stated above; that plan coverage will be maintained during that period; and that both employer and employee contributions will be made by regular payroll deductions for the duration of the extended absence. If the employment relationship is terminated, or if coverage is dropped during the extended absence, the employee will be responsible for repaying the Health Plan for the benefits and services advance.

Signature of Agency Representative: _____ Date: _____