

PFIZER PFRIENDS APPLICATION

Pfizer Pfriends may help you and your family receive savings on your Pfizer medicines.



How do I qualify for Pfizer Pfriends?

You cannot have any prescription drug coverage such as: Medicaid; Medicare prescription drug coverage; state-sponsored prescription drug assistance programs; employee, military, retirement or pension program drug coverage.

How do I apply for Pfizer Pfriends?

Fill out and sign this form and mail the completed form to:

Pfizer Pfriends, PO Box 66543, St. Louis, MO 63166-6543

The Pfizer Pfriends savings program is not health insurance. There are no membership fees to participate in the Pfizer Pfriends program.

For a complete list of participating pharmacies please go to www.PfizerHelpfulAnswers.com or call the toll-free number 866-706-2400. Estimated savings range up to 15-36% and depend on such factors as the particular drug purchased, amount purchased, and the pharmacy where purchased.

For any questions or to enroll over the phone, please call 1-866-706-2400.

Name	Date of Birth	Gender
Applicant:	___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F
Spouse/Domestic Partner:	___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F
1 Dependent #1:	___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F
Dependent #2:	___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F
Address:		
City:	State:	Zip Code:
Telephone: (____) _____ - _____	E-Mail Address (optional):	

2 Total Gross Annual Income: \$ _____ <i>(to determine savings level)</i>	Number of Persons in Household: _____ <i>(include yourself and those you are financially responsible for)</i>
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3 Insurance Information – Are you, your spouse/domestic partner or any of the your dependents:	
a. Covered by insurance for prescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Enrolled in Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Enrolled in Medicare Part D, prescription drug plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No

4 Patient Declaration – By signing below, I/we affirm that my/our answers are complete, true and accurate to the best of my/our knowledge. And <i>I/we understand and attest that:</i>
<ul style="list-style-type: none"> • Completing this application form does not ensure that I/we will qualify for Pfizer Pfriends. • Pfizer may verify the accuracy of the information I/we have provided and may ask for more financial and insurance information. • Any medications purchased at a discount price through Pfizer Pfriends shall not be sold, traded, bartered or transferred. • Pfizer reserves the right to change or cancel the Pfizer Pfriends program at any time. • I/we will promptly contact Pfizer Pfriends if my/our financial status or insurance coverage changes.
Pfizer and Pfizer Patient Assistance Foundation (PPAF) understand your personal and health information is private. The information you provide will only be used by Pfizer, PPAF and parties acting on their behalf to send you the materials you request and other helpful information and updates on the <i>Pfizer Pfriends</i> program.
<input type="checkbox"/> By checking this box, I/we <i>also</i> agree that Pfizer and PPAF and companies acting on their behalf may send me/us materials about other health conditions, use my/our information to develop or improve products and services, or contact me/us in the future about my/our experience with the <i>Pfizer Pfriends</i> program or other health-related topics.

Original Applicant Signature	X	Date:
Original Spouse/Domestic Partner Signature	X	Date:
Original Dependent #1 Signature <i>(Parent or guardian, if under 18 years of age)</i>	X	Date:
Original Dependent #2 Signature <i>(Parent or guardian, if under 18 years of age)</i>	X	Date: