

# Application Form



## Directions

Pfizer Pfriends® may help you receive savings on your Pfizer medicines. To qualify, you cannot have any insurance coverage such as: Medicaid; Medicare prescription drug coverage; state-sponsored prescription drug assistance programs; employee, military, retirement or pension program drug coverage. If you think you might qualify, please complete the steps below:

1. Please answer all the questions under "Your Information." This is required.
2. To apply for other family members, complete the required sections for "Your Spouse" and "Dependents" on the back.
3. **Be sure to sign your name at the bottom of this form. A parent or guardian must sign for dependents under the age of 18.**
4. Mail the completed form to: **Pfizer Pfriends, PO Box 66543, St. Louis, MO 63166-6543**

If you would like help filling out this form or if you have a question about the Pfizer Pfriends program, you can call us. We can be reached toll free at **1-866-706-2400**.

## Your Information (Required Information)

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Address Line 1 \_\_\_\_\_  
(Street number/street name/apartment number)

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Male  Female  Single  Married

Social Security Number/Federal ID# \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(If you DO NOT have an ID#, please call 1-866-706-2400.) (mm/dd/yyyy)

Current Annual Household Income\* \$\_\_\_\_\_,\_\_\_\_\_.00

**\*Household Income:** Any money that comes into the household is included in determining annual household income. If you are married and reside with your spouse, you must include both incomes, regardless of tax filing status. You must also include income earned by dependents living with you. Examples of income include earned wages and/or self-employment earnings; Social Security benefits, disability, SSI disability, or other retirement benefits; VA, military, and government disability pensions; income from rental property; interest on investments; alimony and child support.

How many people are in your household? (Include yourself, your spouse, and any dependents you claim on your tax return.) \_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No Do you have any insurance for prescription medicines?

\_\_\_\_ Yes \_\_\_\_ No Are you enrolled in Medicare?

\_\_\_\_ Yes \_\_\_\_ No Are you enrolled in a Medicare prescription drug plan?

**Optional** Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Race/Ethnic Origin: \_\_\_\_ Asian \_\_\_\_ Black \_\_\_\_ Hispanic \_\_\_\_ White \_\_\_\_ Other

## Agreement and Signatures

### Signatures are required for yourself and others over the age of 18 who are applying on this form.

By signing this form, you agree to receive information on Pfizer Pfriends. You also understand and agree that the information you provide is true to the best of your knowledge. Pfizer may verify the accuracy of the information you provide. Pfizer may change or cancel this program at any time.

Pfizer respects your right to keep your personal and medical information confidential. Pfizer and companies that work with Pfizer will use or disclose your information only to provide you with the benefits of Pfizer Pfriends, unless you also agree to be contacted about other topics, or as required by law. We may also use information that does not identify you personally, such as your age and gender, to evaluate this program or to develop other programs.

May Pfizer Pfriends contact you\* to ask about other topics you may find useful?

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No

Dependent 1 Signature \_\_\_\_\_ Date \_\_\_\_\_  
(parent or guardian signature if under 18)

\_\_\_\_ Yes \_\_\_\_ No

Dependent 2 Signature \_\_\_\_\_ Date \_\_\_\_\_  
(parent or guardian signature if under 18)

\_\_\_\_ Yes \_\_\_\_ No

\* If you answer Yes, we may call you or write to you to ask about health-related issues, or to offer you other Pfizer products or services that may be right for you. We will not ask about your health in particular. Only people over the age of 18 will be contacted. If you answer No, we will only contact you if we have questions about your application or about matters related to Pfizer Pfriends.



**Your Spouse (Required Information)**

If you add your spouse here, he or she does not need to fill out a separate application

First Name \_\_\_\_\_ M.I. \_\_\_\_ Last Name \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Social Security Number/Federal ID#      Date of Birth (mm/dd/yyyy)      Male  Female   
(If you DO NOT have an ID#, please call 1-866-706-2400.)

\_\_\_\_ Yes \_\_\_\_ No Does your spouse have any insurance for prescription medicines?

\_\_\_\_ Yes \_\_\_\_ No Is your spouse enrolled in Medicare?

\_\_\_\_ Yes \_\_\_\_ No Is your spouse enrolled in a Medicare prescription drug plan?

**Optional** Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Race/Ethnic Origin: \_\_\_\_ Asian \_\_\_\_ Black \_\_\_\_ Hispanic \_\_\_\_ White \_\_\_\_ Other

**Dependent 1 (Required Information)**

This section is for dependents you can claim on your tax return. If you would like them to be in Pfizer Pfriends, please provide their information below. For additional dependents, please use a separate sheet of paper and provide the same information as below.

First Name \_\_\_\_\_ M.I. \_\_\_\_ Last Name \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Social Security Number/Federal ID#      Date of Birth (mm/dd/yyyy)      Male  Female   
(If you DO NOT have an ID#, please call 1-866-706-2400.)

\_\_\_\_ Yes \_\_\_\_ No Does this person have any insurance for prescription medicines?

\_\_\_\_ Yes \_\_\_\_ No Is this person enrolled in Medicare?

\_\_\_\_ Yes \_\_\_\_ No Is this person enrolled in a Medicare prescription drug plan?

**Optional** Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Race/Ethnic Origin: \_\_\_\_ Asian \_\_\_\_ Black \_\_\_\_ Hispanic \_\_\_\_ White \_\_\_\_ Other

**Dependent 2 (Required Information)**

First Name \_\_\_\_\_ M.I. \_\_\_\_ Last Name \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Social Security Number/Federal ID#      Date of Birth (mm/dd/yyyy)      Male  Female   
(If you DO NOT have an ID#, please call 1-866-706-2400.)

\_\_\_\_ Yes \_\_\_\_ No Does this person have any insurance for prescription medicines?

\_\_\_\_ Yes \_\_\_\_ No Is this person enrolled in Medicare?

\_\_\_\_ Yes \_\_\_\_ No Is this person enrolled in a Medicare prescription drug plan?

**Optional** Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Race/Ethnic Origin: \_\_\_\_ Asian \_\_\_\_ Black \_\_\_\_ Hispanic \_\_\_\_ White \_\_\_\_ Other

**Additional Dependents: Please use a separate sheet of paper and provide the same information as above.**

