

SAVE \$25 UP TO

on your purchase of COMBIGAN®



SAVE UP TO \$25 and receive valuable information just by filling your prescription for COMBIGAN®

After filling your prescription for COMBIGAN® ophthalmic solution, complete the information below and mail it along with your pharmacy receipt to the address shown below. On your pharmacy receipt, circle the COMBIGAN® name, the prescription number, and your payment amount. In 6 to 8 weeks, you will receive a check equal to \$25 or your amount of payment, whichever is less. Offer not valid for prescriptions purchased under Medicare, Medicaid, certain similar federal or state healthcare programs, or where prohibited by law. Under certain state laws, you may need to disclose your acceptance of offers to your third-party payer (insurer). This rebate must be accompanied by proof of purchase (pharmacy receipt). This certificate must accompany this request. Proof of purchase will not be returned. Eligibility is restricted to individuals: no clubs, groups, or organizations. Offer good only in the USA. Void where taxed or restricted. Please allow 6 to 8 weeks to receive your rebate. One rebate per customer. Offer expires December 31, 2009.

Send this completed form and your pharmacy receipt to:

COMBIGAN® Web Site Rebate Offer
Delta Marketing Dynamics
100 N. Salina Street, Suite 500
Syracuse, NY 13202-1032



Form fields for First Name, MI, and Last Name.

Form field for Address.

Form fields for City, State, and Zip.

I certify that I am not covered by Medicare, Medicaid, or any other federal or state healthcare program and that I have fully disclosed my use of this rebate offer and its terms to my insurance plan or third-party payer.

Signature _____

I do not wish to receive further materials or communication regarding COMBIGAN® products, services, or programs.