



3 MONTHS OF FREE MEDICATION APPLICATION

Thank you for your interest in applying for the chance to receive 3 months of free medication* – up to \$300. When selecting individuals or families we look for the most deserving. The selection process requires completion of this application as well as a picture of you or you and your family.

Every application is reviewed by a member of the Luscinia Health team, but please be aware that we cannot follow up with every application. If we have further questions about you, your family or your situation, we will call you.

Please know that anything you send to us will not be returned so please do not send sentimental photographs.

If you are nominating a person or family you know, please include their information throughout the application. There will be a separate spot on the application for your contact information.

* The amount awarded to selected applicants will be equal to three times the total dollar amount of prescription drug purchases made using the Simple Savings card within a given 30 day period. The maximum awarded amount is \$300.

Please send all completed applications and photographs to:

Luscinia Health
c/o 3 Months Free
5629 FM 1960 W, Suite 234
Houston, TX 77069

THANK YOU!

PART 1) – INDIVIDUAL’S OR FAMILY’S INFORMATION

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: (_____) _____ Work Phone: (_____) _____
 Cell Phone: (_____) _____ E-mail: _____

Card ID: _____
 Cardholder's Name: _____



Marital Status: S / M / D /W If married, how many years? _____

List **ALL** members of household (Including Yourself):

Name Age & DOB Relationship

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____
- 7 _____
- 8 _____

Household Income:

- _____ Under 15,000
 _____ 15,000 – 50,000
 _____ 50,000 – 75,000
 _____ 75,000 – 100,000
 _____ Over 100,000

IF YOU ARE NOMINATING AN INDIVIDUAL OR FAMILY, PLEASE INCLUDE YOUR INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Cell Phone: (____) _____ E-mail: _____

Relationship to the Family: _____

PART 2) – YOUR INDIVIDUAL’S OR FAMILY’S STORY

Please summarize your individual’s or family’s CURRENT situation and prescription drug needs. How will financial assistance with your prescriptions help you? What makes you deserving? (Please keep your answer to one page)

Consent

If selected, your first name and picture(s) may be used in our publications and on our website. By signing below, you waive any rights of privacy and certify that all information stated by you on this Application Form is true.

(Signature)