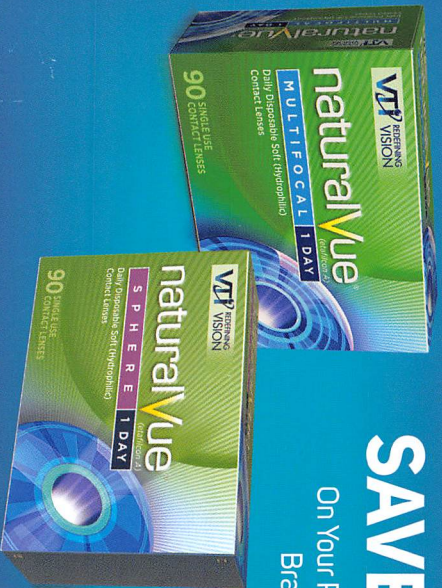


# SAVE UP TO \$100

On Your Purchase of NaturalVue® (etafilcon A)  
Brand 1 Day Contact Lenses – 90 packs



- \$40 off 4 boxes  
(2 end panels required)
- \$100 off 8 boxes  
(2 end panels required)

Please note: Rebate valid for initial purchase of contact lenses only. Rebate submission must be postmarked within 60 days of lens purchase. Contact lenses must be purchased within 90 days of your eye exam, and all receipts must be from the same eye care practitioner who prescribed your contacts. Rebate request will not be processed unless all required items are provided. One rebate per person and up to 2 rebates per address. Checks issued will expire and be null and void if not cashed within 60 days of issue. Rebate expires June 30, 2019. For customer service please call 1-866-622-4816 or email [VTRebates@fulfillment.com](mailto:VTRebates@fulfillment.com). MKT-NVU-RB1 r3



# MAIL-IN REBATE OFFER VALID THROUGH JUNE 30, 2019

## Mail the following items to the address provided below:

1. The completed original rebate form (no photocopies).
2. The appropriate end panels from the NaturalVue® (etafilcon A) Brand 1 Day Contact Lens 90-pack purchase (see illustration to right)  
\$40 rebate – 4 box purchase – 2 end panels required  
\$100 rebate – 8 box purchase – 2 end panels required
3. Sales receipt(s) with the following items circled:
  - Eligible NaturalVue® Brand lens purchase(s) and purchase date
  - Fitting fee exam and date of exam circled.

For illustration purposes only



Check the NaturalVue® Brand purchased:  NaturalVue® Multifocal  NaturalVue® Sphere

Check the Rebate submitted:  4 boxes = \$40 rebate  8 boxes = \$100 rebate

Photocopies of rebate form or end panels will not be accepted; 90-pack purchase only (30-pack end panels will not be accepted). **Allow 8-12 weeks from date of postmark to receive your rebate.**

**Mail to: VTI – Rebate Redemption NV Brand Family, P.O. Box 44903, Atlanta, GA 30336.**

For customer service please call 1-866-622-4816 or email [VTIRebates@fulfillment.com](mailto:VTIRebates@fulfillment.com).

Patient Name(please print): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Email: \_\_\_\_\_

Eye Care Practitioner Name (first/last): \_\_\_\_\_

Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Date Purchased: \_\_\_\_\_

Unsubscribe from VTI communications