THIRD-PARTY PAYOR CLAIM FORM

YOUR CLAIM FORM MUST BE POSTMARKED OR SUBMITTED ONLINE ON OR BEFORE **SEPTEMBER 14, 2026.**

Unless otherwise defined herein, capitalized terms contained in this Claim Form have the same meaning as the Class Action Settlement Agreement.

You may be eligible to receive payment from the $44 million Settlement if you submit a timely and valid Claim Form using the Settlement Website, www.ChantixSettlement.com.

OR

Mail your claim to:

Chantix Settlement
c/o A.B. Data, Ltd.
P.O. Box 173137
Milwaukee, WI 53217

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A THIRD-PARTY PAYOR, NOT INDIVIDUAL CONSUMERS. IF YOU ARE A CONSUMER, PLEASE FILL OUT THE CONSUMER CLAIM FORM.

PART I – CLAIMANT IDENTIFICATION

SECTION A	OR	SECTION B
ONLY IF YOU ARE FILING ON BEHALF OF THE SETTLEMENT CLASS MEMBER COMPANY'S HEALTH PLAN		ONLY IF YOU ARE AN AUTHORIZED AGENT FILING ON BEHALF OF ONE OR MORE THIRD-PARTY PAYOR SETTLEMENT CLASS MEMBERS

Section A: Company or Health Plan Settlement Class Member

Company or Health Plan Name

Contact Name

Address 1

Address 2

City State Zip

Area Code – Telephone Number Tax Identification Number

Email Address

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used since September 29, 2015.

Health Plan Type: (Select one):

☐ Health Insurance Company/HMOHealth Plan ☐ Self-Insured Employee ☐ Self-Insured Health & Welfare Fund

☐ Other (Explain)

Section B: Authorized Agent Only

** As an Authorized Agent, please check how your relationship with the Settlement Class Member(s) is best described:

☐ Third-Party Administrator

☐ Pharmacy Benefit Manager

☐ Other (Explain)

Authorized Agent

Company Name

Contact Name

Address 1

Address 2

City State Zip

Area Code – Telephone Number | Authorized Agent's Tax Identification Number

Email Address

Please list the name and FEIN of every Settlement Class Member (i.e., Company or Health Plan) for whom you have been duly authorized to submit this Claim Form (attach additional sheets to this Claim Form as necessary).

Alternatively, you may submit the requested list of Settlement Class Member names and FEINs in an electronic format, such as in Excel or a tab-delimited text file saved on a disk. Please contact the Settlement Administrator to determine what formats are acceptable.

THIRD-PARTY PAYOR'S NAME	THIRD-PARTY PAYOR'S FEIN

PART II – AMOUNT CLAIMED

Please type or print in the box below, the total amount paid or reimbursed for Chantix in the United States and its territories, net of co-pays, deductibles, and co-insurance, from September 29, 2015 through September 17, 2021.

Please note that certain groups have been excluded from the Settlement Class in this case. Do not submit a claim for, or on behalf of, any of the following excluded groups:

a. Pfizer, Inc., and its officers, directors, managers, employees, subsidiaries, and affiliates ("Defendant");

b. Government agencies or governmental actors, including, without limitation, any state Attorney General office; and

c. Any entity that previously opted out of the Settlement Class in this Action.

CHANTIX PRESCRIPTIONS	**TOTAL AMOUNT PAID**
Purchases or reimbursements between September 29, 2015, through September 17, 2021, for Chantix.	$

You must submit claims data and information in support of the purchase amounts stated above. Instructions on how to do so are found in the claims documentation instructions on the Settlement Website or included with this Claim Form.

PART III – CERTIFICATION

I (We) have read and am (are) familiar with the contents of this Claim Form. I (We) certify that the information I (we) have set forth above and in any documents attached by me (us) are true, correct, and complete to the best of my (our) knowledge. I (We) certify that I (we) or the Third-Party Payor Settlement Class Member(s) that I (we) represent paid the total amount set forth above in out-of-pocket expenditures for purchases or reimbursements of Chantix in the United States and its territories from September 29, 2015 through September 17, 2021, inclusive. I (We) further certify that I (we) or the Settlement Class Member(s) that I (we) represent did not opt out of the Settlement Class in this Action. Nor did I (we) or the Settlement Class Member(s) purchase Chantix for purposes of resale. In addition, I (we) (1) have not (or the Settlement Class Member has not) served as counsel, officer, director, agent, or employee of Defendant, or a corporate parent, subsidiary, affiliate, or other related entity thereof; and (2) am not a governmental actor, including, without limitation, employed by any state Attorney General office.

To the extent I (we) have been given authority to submit this Claim Form by a Settlement Class Member(s) on its behalf, and accordingly am submitting this Claim Form in the capacity of an authorized agent with authority to submit it by the Settlement Class Member(s) identified on a separate sheet of paper submitted with this Claim Form, and to the extent that I (we) have been authorized to receive payment on behalf of this Settlement Class Member(s): in the event amounts from the Settlement Fund are distributed to me (us) and a Settlement Class Member(s) later claims that I (we) did not have authority to claim and/or receive such amounts on its behalf, I (we) and/or my (our) employer will hold the Settlement Class, Class Counsel, and the Settlement Administrator harmless with respect to any claims made by the Settlement Class Member(s).

I (We) hereby submit to the jurisdiction of the United States District Court for the Southern District of New York for all purposes connected with the Claim Form, including resolution of disputes relating to this Claim Form. I (we) acknowledge that any false information or representations contained herein may subject me (us) to sanctions, including the possibility of criminal prosecution. I (we) agree to supplement this Claim Form by furnishing additional documentary backup for the information provided herein, upon request of the Settlement Administrator. I understand that Claims will be audited for veracity, accuracy, and fraud. Claim Forms that are not valid and/or illegible may be rejected, including but not limited to failure to provide wet signatures if requested by the Settlement Administrator.

I certify under penalty of perjury that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Claim Form was executed this __ day of _____, 2026.

Signature	Position/Title
Print Name	Date

If you have not completed this Claim Form online and submitted it electronically through the Settlement Website, you must mail the completed Claim Form, along with any supporting documentation as described above, postmarked on or before **September 14, 2026**, to the following address:

Chantix Settlement
c/o A.B. Data, Ltd.
P.O. Box 173137
Milwaukee, WI 53217

Toll-Free Telephone: 1-877-354-3912 Website: www.ChantixSettlement.com

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form. Attach or upload any documentation supporting your claim.

2. Keep a copy of your Claim Form and supporting documentation for your records.

3. If you move and/or your name changes, please send your new address and/or your new name or contact information to the Settlement Administrator via the Settlement Website or U.S. Mail. The addresses are listed above.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

In re Chantix (Varenicline) Mktg., Sales Pracs. & Prods. Liab. Litig.	Case No. 22-MD-3050 (KPF), 22-MC-3050 (S.D.N.Y.)

INSTRUCTIONS FOR SUBMITTING YOUR THIRD-PARTY PAYOR CLAIM FORM

The information you provide will be kept confidential and used only for administering this Settlement. If you have any questions, please call the Settlement Administrator at 1-877-354-3912.-

A Third-Party Payor Settlement Class Member or an authorized agent can complete this Claim Form. If both a Settlement Class Member and its authorized agent submit a Claim Form, the Settlement Administrator will only consider the Settlement Class Member's Claim Form. The Settlement Administrator may request supporting documentation. The claim may be rejected if any requested documentation is not provided in a timely manner.

If you are a **Settlement Class Member** submitting a Claim Form on your own behalf, you must provide the information requested in "**Part 1, Section A – COMPANY OR HEALTH PLAN CLASS MEMBER ONLY**," in addition to the other information requested by this Claim Form.

If you are an **authorized agent** of one or more Settlement Class Members, you must provide the information requested in "**Part 1, Section B – AUTHORIZED AGENT ONLY**," in addition to the other information requested by this Claim Form.

You may submit a separate Claim Form for each Settlement Class Member OR you may submit one Claim Form for all such Settlement Class Members, as long as you provide the information required for each Settlement Class Member on whose behalf you are submitting the form.

If you are submitting Claim Forms both on your own behalf as a Settlement Class Member AND as an authorized agent on behalf of one or more Settlement Class Members, you should submit one Claim Form for yourself, completing Section A and another Claim Form or Forms as an authorized agent for the other Settlement Class Member(s), completing Section B. **Do not submit a Claim Form on behalf of any Settlement Class Member unless that Settlement Class Member provided prior authorization for you to submit the Claim Form.**

In order to qualify to receive a payment from this Settlement, you must complete and submit this Claim Form either on paper or electronically on the Settlement Website, and you may need to provide certain requested documentation to substantiate your claim.

Your failure to complete and submit the Claim Form postmarked or filed online by **September 14, 2026** will prevent you from receiving any payment from this Settlement. Submission of this Claim Form does not ensure that you will share in the payments related to the Settlement. If the Settlement Administrator disputes a material fact concerning your claim, you will have the right to present information in a dispute resolution process.

CLAIM DOCUMENTATION REQUIREMENTS

You must provide all the information requested in "Part II: Amount Claimed." You must submit claims data and information in support of the purchase amounts stated above. Your claimed purchase amounts of Chantix must be net of co-pays, deductibles, and co-insurance.

If you must submit claims data and information, it is mandatory that you provide the data for all categories listed below. Claim Forms that do not include the information listed below will not be accepted.

a) TPP Settlement Class Member's Name;

b) Unique patient identification number or code;

c) National Drug Code ("NDC") (a list of NDCs is included in this Claim Form) – e.g., 00000-0000-00;

d) Fill Date or Date of Service – e.g., 09/30/2019;

e) Location (State) of Service – e.g., CA;

f) Amount Billed (not including dispensing fee) – e.g., $40.00; and

g) Amount Paid by TPP net of co-pays, deductibles, and co-insurance – e.g., $20.00.

If you are submitting a Claim Form on behalf of multiple Settlement Class Members, also provide the following information for each prescription:

h) Plan or Group Name, and

i) Plan or Group FEIN – provide group number for each transaction.

Information submitted will be covered by the Protective Order entered by the Court. For your convenience, an exemplar spreadsheet containing these categories is located on the File a Claim page of the Settlement Website. In addition, an Excel spreadsheet can be downloaded from the Settlement Website, www.ChantixSettlement.com. Please use this format if possible. A list of the NDCs that will be considered by the Settlement Administrator is provided below:

Chantix NDCs	Name	Seller
0069-0468-56	Chantix	Pfizer
0069-0469-03	Chantix	Pfizer
0069-0469-11	Chantix	Pfizer
0069-0469-12	Chantix	Pfizer
0069-0469-56	Chantix	Pfizer
0069-0471-02	Chantix	Pfizer
0069-0471-03	Chantix	Pfizer

If possible, please provide the electronic data in either Microsoft Excel format or ASCII flat file pipe "|" or tab-delimited or fixed-width format.

Please contact the Settlement Administrator at 1-877-354-3912 with any questions about the required claims data.