AlphaMed Inc.

# INSTRUCTION FOR FILLING CUSTOMER APPLICATION

1. FILL OUT APPLICATION, DOWNLOAD, SAVE AND SIGN
2. EMAIL SIGNED APPLICATION TO APPLICATION@ALPHAMED-RX.COM
3. ATTACH A COPY OF PHARMACY LICENSE AND LICENSE VERIFICATION
4. ATTACH A COPY OF A VOIDED CHECK

Customer Application

## Company Information

Company Name:

Company Address:

City: State : Zip:

Contact Person: Title

Telephone Number: Fax Number:

Email:

Type of Corporate Structure: C-Corp: S-Corp: LLC: Partnership : Sole proprietorship :

Type of Business: Lenght of time in Business:

Federal Tax #: Home State License #: Expiration Date:

## Shipping & Billing Information

Shipping Address:

City: State : Zip:

Contact Person: Title

Telephone Number: Email:

Billing Address same as Ship to:

Billing Address:

City: State : Zip:

Contact Person: Title

Telephone Number: Email:

## Trade References

| Business Name | Business Address | Contact Name | Telephone |
|---|---|---|---|

## Payment Information

Accounts Payable Contact

Telephone Number: Email:

## Bank Information

Account Type: Checking: Savings: ***N.B. ATTACH A COPY OF VIODED CHECK***

Bank Name: Account Name:

Bank Routing Number: Account Number:

## Card Information

Card Type: MasterCard: Visa: Discover: American Express:

Credit Card Number: Expiration Date: CVV:

CardHolder's Name:

Credit Card Billing Address:

City: State : Zip:

Email:

You agree to pay invoices by recurring e-check (or "ACH") debits and/or credit card charges. By completing this form you authorize AlphaMed Rx Inc. ("AlphaMed") to debit or charge your respective accounts from time-to-time for the payment of your invoices. The amount debited or charged will based upon your orders. You authorize "AlphaMed" to debit or charge your account(s) in the amount invoiced plus applicable interest, collection or such fees. You agree that "AlphaMed"'s invoice shall be sufficient notice of a forthcoming debit or charge and that no other prior-notification is required. If for some reason the amount invoiced changes by 20% or more prior to being processed, "AlphaMed" will notify you of the change.

You acknowledge and agree that this authorization ("Authorization") shall remain in effect until canceled in writing, which cancellation shall be effective after either all amounts invoiced paid OR new payment information has been provided to and verified by "AlphaMed". If any change occurs to the financial accounts provided in this Authorization, You agree to notify "AlphaMed" of such change prior to placing a new order and/or immediately upon the change occurring. When payment of an invoice is due on a weekend or holiday, you understand that the payment may not be processed by "AlphaMed" until the next business day. Because this is an electronic transaction, you understand that the debit or charge may occur as early as the due date stated on each invoice. Should any debit or charge attempted by "AlphaMed" be denied for any reason, you understand that "AlphaMed" may, at its discretion, repeatedly attempt to process the payment until payment in full has been completed. You agree to pay a $50.00 fee for each such attempt that is declined. You agree not to dispute a recurring billing with my bank so long as the transactions are consistent with the terms and conditions of this Authorization and with all other terms and conditions you agreed to in connection with my New Account Application ("Account Application"). You represent and warrant that you are an agent of the party completing this Authorization and are authorized to execute this Authorization on their behalf. You consent to the foregoing by signing below authorize "AlphaMed" to debit or charge the above identified financial account for all product, services and/or invoices provided to you by "AlphaMed". You agree that 3% administrative fee may be added to each invoice paid by credit card. "AlphaMed" represents that it will take reasonable measures to keep all banking and credit card information confidential and secure.

**Print Name** **Title** **Signature** **Date**