HyGen™ Pharmaceuticals, Inc.

8635 154th Ave NE
Redmond, WA 98052

Phone: 877-630-9198
Fax: 425-451-8964
Web: www.HyGenPharma.com

Customer Application
Retailer/Physician – OTC and Rx – Checklist

Thank you for choosing to do business with HyGen Pharmaceuticals, Inc. Please take a few minutes to fill out and fax or scan and email over the following items.

	Description
☐	Credit Application Form – Required Completely filled out including 2 trade references.
☐	Copy of Customer's State License – Required Required to purchase Rx Pharmaceuticals.
☐	Copy of Customer's DEA License – Required
☐	Terms and Conditions – Required
☐	Duplicate and Deposit Faxed Checks – Optional Required if payment made by faxing copies of checks.
☐	WA State Resale Certificate – Optional Required for ALL WA Customers.
☐	Prescription Drug Exemption Certificate – Optional Required for ALL WA customers.

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Please fax **Completed Application**, **DEA License**, and **State Board of Pharmacy License** to 425-451-8964. If you have any questions, call toll free 877-630-9198.

Company Information:

Company Name: _____ DBA: _____

Business Type: ☐Retail Pharmacy-Independent ☐Retail Pharmacy-Chain ☐LTC

☐ Specialty ☐Mail Order ☐ Institutional/Hospice

Average Scripts per Day: _____ Specialty: _____

Billing Address: _____ **Shipping Address**: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Tax ID #: ___-_____ **RemoteNet:**

Email: _____

Contact Information:

Contact Person for Purchasing: Contact Person for Accounts Payable:

Name: _____ Name: _____

Phone/Extension: _____ Phone/Extension: _____

Email: _____ Email: _____

Trade References:

Primary Vendor: _____ Other Vendor: _____

1. Company Name: _____ Contact Person: _____

   Phone: (_____) _____-_____ Fax: (_____) _____-_____ A/C # _____

2. Company Name: _____ Contact Person: _____

   Phone: (_____) _____-_____ Fax: (_____) _____-_____ A/C # _____

Primary Bank Information:

Bank Name: _____ Officer's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

I hereby certify that the above information is true and correct. The information included in this application shall be used by HyGen Pharmaceuticals, Inc. to determine the amount of credit that can be extended to the above named company. I understand that HyGen Pharmaceuticals, Inc. may utilize other sources of credit, which it deems necessary in determining the credit status. I hereby authorize the bank & trade references to release the needed information listed above and also certify that I am authorized to execute this agreement.

Printed Name (Owner/Officer):_____ Title: _____

Signature: _____ Date: _____

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Terms and Conditions – Retailer/Physician

Payments and Credits:

- Payment terms are **10 EOM for Generics and Net 7 Days for Brands** with approved credit unless negotiated differently.
- Payments by check should be made payable to: **HyGen Pharmaceuticals, Inc.**
- Orders have to be **pre-paid** if paying by credit card. We accept **MasterCard, Amex,** and **Visa** at the time of shipping.
- Payment is due in accordance to the terms reflected on the invoice. HyGen shall charge interest at the rate of 1.5% per month if payment is delayed.
- We will credit your payment to your oldest invoice or statement unless your remittance document reflects the invoice being paid or the payment exactly matches a specific invoice or statement amount.

Shipping:

- We provide free 2ND Day shipping on orders over $150.00.
- We offer Next Day shipping on all orders over $250.00 with the exception of bulk quantities, liquids, suspensions & inhalers that are shipped Ground only.
- Any damage or shortage of product received **must be notified to us within one business day of delivery.**

Returns:

- Full credit will be given for shipping errors and products damaged in transit, provided the error or damage is reported to us within 24 hours of receipt of the product.
- All returns must be authorized in advance by contacting customer service and obtaining an authorization.
- We reserve the right to charge **a 20% restocking fee.**
- If the removal of price stickers damages the product package, the product must be destroyed and no credit will be issued.
- Products whose labels have been altered, defaced or damaged as deemed by HyGen Pharmaceuticals, Inc. are not eligible for credit.
- **No returns will be accepted on refrigerated items including vaccines or biological products.**
- We reserve the right to return or destroy products that are ineligible for credit or are sent without prior authorization.
- Allow one to two weeks processing time for credit memos on authorized returns. Please do not deduct any amounts from your payment related to the returned product before receiving a credit memo.

Guarantee:

- The undersigned personally guarantees the prompt and full performance of all obligations due and owing by Applicant to HyGen Pharmaceuticals, under this and/or any other agreement with HyGen Pharmaceuticals. In the event of default, HyGen Pharmaceuticals and/or any holder hereof is authorized to proceed against the undersigned guarantor, without first having to proceed against Applicant, for the full amount due, including late payment charges and interest. The undersigned further agrees to reimburse HyGen Pharmaceuticals all costs of collection including reasonable attorneys' fees. The undersigned waives presentment, demand, protest, notice of protest, notice of dishonor and any and all other notices or demands of whatever character to which the undersigned might otherwise be entitled. The undersigned further consent to any extension granted by HyGen Pharmaceuticals and waives notice thereof. If more than one guarantor, the obligation of each shall be joint and several. Termination of this guarantee must be in writing, signed by HyGen Pharmaceuticals and undersigned, and in such event, shall only apply as to future obligations.

I hereby acknowledge and accept the Terms and Conditions described above and that your Conditions of Sale will apply exclusively to all dealings between our companies.

Duly authorized for and on behalf of _____ Date: _____

Print Name _____ Signature_____

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ACH Payment Authorization Form

Customer Name: _____

Customer Account #: _____

Schedule your payment to be automatically deducted from your checking or savings account.
Just complete and sign this form to get started!

ACH Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How ACH Payments Work:
You authorize monthly scheduled charges to your checking or savings account. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 5 days prior to the payment being collected.

Please complete the information below:

I _____ authorize HyGen Pharmaceuticals Inc., to charge my bank Account indicated below on the 10th day of month for Generic purchases, and Net 7, Due Friday for Brand purchases, or according to the agreed upon payment terms.

Billing Address: _____

Phone# _____ Email: _____

Account Type: ☐ Checking ☐ Savings

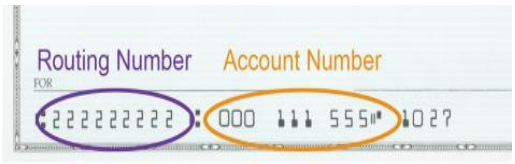
Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____



SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify HyGen Pharmaceutical Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that HyGen Pharmaceuticals, Inc. may at its discretion attempt to process the charge again within 7 days, and agree to an additional $30/- charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this ACH payment with my bank so long as the transactions correspond to the terms indicated in this authorization form.

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Duplicate & Deposit Faxed Check Authorization Form

(Only required if paying by Faxed Check)

It is required that we have on file a note stipulating that HyGen Pharmaceuticals, Inc. is authorized to "Duplicate and Deposit" your faxed checks.

Please sign below and fax this Authorization back to us at 425-451-8964 so that we can have it on file.

Please mention "Duplicate and Deposit" on the check that is faxed to us along with the invoice numbers being paid.

Thank you,
Accounting Department
HyGen Pharmaceuticals, Inc.

I, _____, authorize HyGen Pharmaceuticals, Inc. to duplicate and deposit all faxed checks.

Company Name: _____

Signature: _____

Date: _____

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Resale Certificate
(WA Customers Only)

Please fax us a copy of your resale certificate along with a copy of your pharmacy license and other documents.

Thank You,

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Prescription Drug Exemption Certificate

(WA Customers Only)

Name of Purchaser: _____

Address of Purchaser: _____

_____

I hereby certify: That I am a registered Washington tax payer. I may legally prescribe or dispense drugs or other substances. I further certify that the drugs and other substances listed below purchased from _____ will be prescribed and used for the treatment of illness or ailments of human beings. I shall maintain invoices and prescriptions or such other records as are necessary to account for the disposition of the drugs or other substances for which I have not paid retail sales tax. In the event that any such drug or substance is used without a prescription being issued, it is understood that I am required to report and pay use tax measured by its purchase price. If I have indicated that this is a blanket certificate, this certificate shall be considered part of each order which I may hereafter give to you, unless otherwise specified, and shall be valid for a period of four years or until revoked by me in writing.

Description of drugs and other substances to be purchased:

_____

_____

Single Purchase: _____ **Blanket Certificate:** _____

(Indicate by checkmark if the certificate is for a single purchase or continuing purchases.)

Authorized Agent or Purchaser:

Printed Name and Title: _____

Signature: _____

Date: _____