

Customer Application Independent – 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	
<input type="checkbox"/>	Credit Application Form – <u>Required</u> Completely filled out including 2 trade references.
<input type="checkbox"/>	Copy of Customer’s State License – <u>Required</u> Required for all new customers.
<input type="checkbox"/>	Copy of Customer’s DEA License – <u>Required</u> Required for all new customers.
<input type="checkbox"/>	Terms and Conditions – <u>Required</u> Required for all new customers.
<input type="checkbox"/>	Duplicate and Deposit Faxed Checks – <u>Optional</u> Required if payment made by faxing copies of checks.
<input type="checkbox"/>	ACH Payment Authorization Form – <u>Optional</u> Required if payment made by ACH.
<input type="checkbox"/>	WA State Resale Certificate – <u>Optional</u> Required for ALL WA Customers.
<input type="checkbox"/>	Prescription Drug Exemption Certificate – <u>Optional</u> Required for ALL WA customers.

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 / Non-Warehousing Retail / Warehousing LTC
 Mail Order Institutional/Hospice Specialty _____ Other _____

Average Scripts per Day: _____ Number of pharmacies: _____

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

City: _____ City: _____

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

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

Tax ID #: ____ - _____ **Online Access 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: _____

GPO Membership: _____

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: _____

Terms and Conditions

Payments and Credits:

- Customer agrees to pay HyGen Pharmaceuticals, Inc. ("HyGen") at **10 EOM** for Generics, and at **Net 7, Due Friday** for Brand items with approved credit, unless mutually agreed otherwise in writing.
- Payments by check should be made payable to: **HyGen Pharmaceuticals, Inc.**
- Customer shall pay HyGen a \$30 fee for each bounced check or ACH Transaction rejected due to non-sufficient funds.
- Customer shall pre-pay for orders if paying by credit card. HyGen accepts MasterCard, Visa, and American Express at the time of shipping.
- Customer shall pay HyGen in accordance to the terms reflected on the invoice. Customer shall pay HyGen interest at the rate of 1.5% per month on all amounts past due.
- HyGen shall credit Customer's payment to the oldest invoice or statement unless Customer's remittance document reflects the invoice being paid or the payment exactly matches a specific invoice or statement amount.
- Credits for returned goods are subject to the most current version of HyGen's Returned Goods Policy.

Shipping:

- HyGen provides free shipping on all orders greater than \$150.00.
- Bulk quantities, hazardous items, liquids, suspensions & inhalers are shipped via Ground only.
- Any damage, product shortage, or other discrepancy **must be notified to HyGen within one business day of delivery** to be eligible for credit.

Governing Law/Venue/Jurisdiction:

- This Agreement shall be governed by the Laws of the State of Washington. The Parties hereby irrevocably submit to the exclusive jurisdiction of any federal or state court located within the County of King, State of Washington over any dispute arising out of or relating to this Agreement or any of the transactions contemplated hereby and agree that all claims in respect of such dispute or any suit, action proceeding related thereto may be heard and determined in such courts.

Guarantee:

- The undersigned personally guarantees the prompt and full performance of all obligations due and owing by Customer to HyGen under this and/or any other agreement with HyGen. 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 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 and undersigned, and in such event, shall only apply as to future obligations.

Fees and Costs:

- In the event of default in any payment or other obligation to HyGen, Customer agrees to reimburse HyGen for any and all attorney's fees, court and other costs and expenses reasonably incurred in collecting or enforcing these Terms and Conditions.

I hereby acknowledge and accept the Terms and Conditions described above and agree that they shall apply exclusively to all dealings between our companies.

Duly authorized for/on behalf of (company name) _____, as well as by the undersigned in his/her corporate capacity as Guarantor:

Print Name _____ Title: _____

Signature _____ Date: _____

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 those terms which have been negotiated and agreed upon in writing.

Billing Address: _____

Phone# _____ Email: _____

Account Type:	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
Name on Acct	_____	
Bank Name	_____	
Account Number	_____	
Bank Routing #	_____	
Bank City/State	_____	



The graphic shows a routing number '222222222' circled in purple and an account number '000 111 555 1027' circled in orange. The text 'Routing Number' and 'Account Number' are written above the respective numbers.

SIGNATURE _____

DATE _____

Customer understands that this authorization will remain in effect until Customer cancels it in writing, and Customer agrees to notify **HyGen Pharmaceuticals, Inc.** in writing of any changes in payment 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, Customer understands that the payment may be executed on the next business day. Customer understands that because this is an electronic transaction, these funds may be withdrawn from Customer's 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. Customer acknowledges that the origination of ACH transactions to Customer's account must comply with the provisions of U.S. law. Customer agrees not to dispute this ACH payment with Customer's bank so long as the transactions correspond to the terms indicated in this authorization form.

Returned Goods Policy

- All returns must be authorized in advance by contacting Customer Service and obtaining written authorization.
- A 20% restocking fee will be assessed on all returned goods, with the exception of returns due to in-transit damage or any discrepancy caused by HyGen.
- If the removal of price stickers damages the product package, the product is ineligible for credit and will be destroyed.
- Products which have been opened, or whose labels have been altered, defaced or damaged as determined by HyGen Pharmaceuticals, Inc. are not eligible for credit.
- No returns will be accepted on cold chain items, controlled substances, items which have been special ordered for Customer, or items which are otherwise indicated as non-returnable.
- HyGen reserves the right to destroy products that are sent without prior authorization. Credit will not be issued for such items.
- HyGen reserves the right to refuse bulk returns, returns from inactive accounts, accounts with overdue balances, or accounts in the process of closing.
- HyGen reserves the right to refuse any and all returns from Customer if HyGen suspects the goods may be counterfeit, adulterated, unsaleable, outdated, or otherwise not in compliance with the Returned Goods Policy, or if Customer has previously attempted to return such goods to HyGen.
- Restocking, handling, and return freight charges may be deducted from return credit at HyGen's discretion.
- 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.

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: _____

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,

HyGen Pharmaceuticals, Inc.

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: _____