MEDPlus SERVICES USA

CUSTOMER APPLICATION

CONTENTS:

REQUIREMENTS CHECKLIST:

- ❑ Complete pages 2 – 5 and return
- ❑ Return copy of Sales Tax Exemption for your state (**REQUIRED)**
- ❑ Return copy of Pharma License, if you have one
- ❑ Sign Disclosure page and return
- ❑ Complete Credit Card Authorization and return

Delivering Efficiency to Healthcare™

MedPlus Services USA, a division of NDC, Inc.

402 BNA Drive, Suite 500 / Nashville, TN 37217
877.436.5378 / fax 615.678.0126
www.medplusonline.com / info@medplusonline.com

CUSTOMER APPLICATION

Date: _____

*APPLICATION FEE $100

Check Method of Payment: ☐ Check Enclosed ❑ Use Credit Card

- An application fee of $100 is required.
- Fee will be reimbursed if $3,000 is purchased within 90 days of account establishment.

*REQUIRED INFORMATION

*Estimated MedPlus Annual Purchases: $_____ Annual Sales Volume: $_____

*Contact(s) – A/P: _____ Email: _____

Purchasing: _____ Email: _____

*Business Name: _____ Date Established: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

*Phone Number: _____ *Fax Number: _____

Website: _____

*Bill To Address: _____

*Ship To Address: _____

Business Formerly By Another Name: _____

*Invoices *(please check one)*: ❑ Email ❑ Fax *Acknowledgments *(please check one):* ❑ Email ❑ Fax

Email: _____ Email: _____

*SALES BREAKDOWN BY PERCENTAGE:

Hospital: _____% Doctor/Clinic: _____% Nursing Home: _____% Dental:_____%

Home Care: _____% Lab: _____% Veterinary: _____% Other: _____%

Do you buy Covidien/Kendall/ Mallinckrodt/US Surgical Direct? ❑ Yes ❑ No Acct.#: _____

*Type of Ownership *(please check one)*: ❑ Proprietorship ❑ Partnership ❑ Corporation

If Corporation,
Date of Inc: _____ State of Inc: _____ Public: _____ Private: _____

*OWNERS / OFFICERS:

Name: _____ Title: _____ Own: _____%

Name: _____ Title: _____ Own: _____%

Name: _____ Title: _____ Own: _____%

(List Of Ownership To Include Not Less Than 51% Of Total)

Additional Officers / Key Personnel

Name: _____ Title: _____

Employed Since: _____

Name: _____ Title: _____

Employed Since: _____

Name: _____ Title: _____

Employed Since: _____

* CREDIT INFORMATION

Bank Reference:

Name: _____ Account #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Credit References: *(Fax Number must be included for processing)*

Company Name: _____ Contact: _____

Account #: _____ Phone: _____ Fax: _____

Company Name: _____ Contact: _____

Account #: _____ Phone: _____ Fax: _____

Company Name: _____ Contact: _____

Account #: _____ Phone: _____ Fax: _____

Company Name: _____ Contact: _____

Account #: _____ Phone: _____ Fax: _____

Corporate Credit Card used for Product Purchases? ❑ Yes ❑ No

If yes, please complete and return Credit Card Authorization with your application.

* Authorized Signature: _____

Title: _____ Date: _____

Thank you for your interest in MedPlus Services, USA. Print and complete this form.
Fax to: 615.678.0126. You will be contacted if further information is required.

Any documents/pages that are part of this application that are faxes to MedPlus will be considered to be originals and accepted as such by MedPlus, its successors and assigns. MedPlus reserves the right to request the original documents for file purposes. Applicant agrees to supply originals if requested.

DISCLOSURES

ECOA NOTICE

The Federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age (provided the applicant has the capacity to contract); because all or part of the applicant's income derives from any public assistance program; or because the applicant has in good faith exercised any right under the Consumer Protection Act. The federal agency that administers compliance with this law concerning this creditor is the Federal Trade Commission, Equal Credit Opportunity, Washington, DC 20580.

FCRA NOTICE

The undersigned individual who is either a principal of the credit applicant or a sole proprietorship understands and agrees that credit history may be a factor in the evaluation of the applicant, and hereby consents to and authorizes the use of a consumer credit report on the undersigned by the above named business credit grantor, from time to time and as may be needed, in the credit evaluation process.

LIABILITY FOR COLLECTION FEES AND COSTS

The undersigned agrees to pay any and all collection costs if this account is referred for collection, or if suit is brought to collect this account. Further it is agreed that the undersigned will pay all costs and reasonable attorney's fees, including all costs and a reasonable attorney's fee incurred on the any appeal to the appellate court.

AUTHORIZATION TO PURCHASE AND MAKE CREDIT INQUIRY

The undersigned is authorized to make purchases and grants permission of National Distribution & Contracting, Inc. to make inquiry on financial, credit and related matters at applicant's financial institution(s), lending firm(s) and references listed elsewhere on this application and they are hereby authorized to give you any information their files contain.

Under penalties of perjury, I swear or affirm that the information provided is true and correct as to every material matter. I authorize release of information to MedPlus Services USA by the references above. I have read and agree to the Terms and Conditions as listed on page 7.

Dated this _____ Day of _____, 20_____

_____ _____

Authorized Signature Company Name

_____

Print Name & Title

NOTE:

- This form must be signed and returned with your application.
- No application can be processed without a copy of this form.

CUSTOMER CARD AUTHORIZATION

*ALL MUST MATCH

Date: _____

* I, _____ give MedPlus Services USA, hereafter called MedPlus, permission to process all charges relating to any present or future order (if requested) to the below referenced credit card. I understand that by placing a phone order and not signing the credit card transaction, that I will not be entitled to an actual signed receipt. My signature below gives MedPlus the authority to process all requested transactions to the credit card listed. Any disputes that may arise from shipping errors (shortages or damages) must be reported to MedPlus within 72 hours from receipt of merchandise so that proper action may be taken.

* Signature: _____

Title: _____

Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Credit Card Number: _____

Card Type: ❑ Visa ❑ MasterCard Exp. Date: _____ CW code: _____

* Name on the Credit Card: _____

Billing Address for Card:

Street Address:_____

City: _____ State: _____ Zip: _____

Phone Number: _____

After completing all of the above requested information, please attach a copy of the card (front & back) to this authorization form. MAIL form to MedPlus Services USA, 402 BNA Drive, Suite 500, Nashville, TN 37217 or FAX form to (615) 678-0126. If you have any questions concerning this or any matters relating to a credit card transaction, please direct your call to 877.436.5378.

(VISA or MASTERCARD)

Any documents/pages that are part of this application that are faxes to MedPlus will be considered to be originals and accepted as such by MedPlus, its successors and assigns. MedPlus reserves the right to request the original documents for file purposes. Applicant agrees to supply originals if requested.

EXEMPTION CERTIFICATE

SALES & USE TAX EXEMPTION CERTIFICATE

NOTE:

- **A copy of the sales and use tax exemption certificate issued by your state must accompany this application.**
- **No multijurisdictional forms will be accepted.**

If your exemption certificate bears an expiration date, such as Florida's annual expiration date, you agree to supply new certificates to MedPlus Services USA within 14 days from receipt of the new certificate. MedPlus reserves the right to suspend shipments and/or charge any applicable sales and/or use taxes if your certificate(s) has/have expired.

Applicant agrees to pay any and all sales and or use taxes assessed by MedPlus because of expired certificates without dispute or delay.

New annual forms must be faxed to: 615.208.1686 / credit@ndc-inc.com each year

SHIPPING SCHEDULE

All orders under $2,000 received prior to 2:00pm CST will ship next business day.
Orders under $2,000 received after 2:00pm CST will ship second business day.

All orders over $2,000 will ship on the day designated for your geographic location. You will be provided your designated ship day when you receive your medplusonline.com login information. Backordered product from orders over $2,000 will be consolidated to ship on your next scheduled ship day.

We recommend use of our website for order placement as it provides the most expeditious order processing and allocation of stocked items to your order. We do accept faxed (615.367.4520) or emailed (info@medplusonline.com) orders and they will be processed in the order in which they are received.

TERMS

Net 30 days from date of invoice based on satisfactory credit standing. Special terms and conditions may be established in lieu of open credit, i.e. Credit Card, CIA, etc. Any account that is inactive for one (1) year, will be assessed a $300 access fee payable annually to maintain access to website, products and programs.

SHIPPING POLICY

All shipments are F.O.B. Destination on orders greater than $2,000 to customer's assigned ship to location within continental United States plus a $30 shipment charge and a fuel recovery charge (FRC) of 1.35% on product total. FRC percentage is subject to change without notice. Orders under $2,000, shipped from stock, will be charged actual freight. Carrier used will be at MedPlus discretion – other arrangements with MedPlus approval. Drop ship fee of $15.00 applies to all warehouse orders not shipped to your company warehouse.

QUOTED PRICES

All prices are exclusive of Federal or State taxes of any type. Prices are subject to change without notice and all orders subject to acceptance by Customer Service. Prices are based upon MedPlus pricing at time of order acceptance.

PLACING ORDERS

Orders may be placed via the internet through medplusonline.com. Fax (615.367.4520) or email (info@medplusonline.com) orders also accepted.

RETURN GOODS & LOSS/DAMAGE POLICY

RETURNED GOODS

1) All requests for return product should be faxed to Customer Service: 615.367.4520 or entered on the website. No returns will be accepted without "RGA" and only those products and quantities approved should be returned to the warehouse.

2) Return of misshipments or defective products can be returned any time without freight charges. Customer Service will make arrangements for pick-up (call tags).

3) All products returned with expiration dating must meet product shelf life guidelines of at least 6 months. All returned products must be in original container and free of any labels or other markings. Certain equipment returns may be subject to vendor restrictions.

4) Products returned within 45 days will not be assessed a restocking charge. Products returned after 45 days will be assessed a 25% restocking charge. Products not stocked in the MedPlus warehouse are not returnable for credit unless shipped in error. Products over 120 days can not be accepted as returnable.

5) Any products purchased from MedPlus for which a pharmaceutical pedigree was issued are not returnable unless shipped in error or defective.

To help us process your credits promptly, please review the following:

- Customer should provide invoice number and PO.
- Returns will not be accepted without Return Goods Authorization (RGA).
- Returns must be made within 30 days of RGA*.
- Customer Service will issue RGA within 24 hours.
- Credits issued to customer immediately upon receipt in warehouse.

RETURN TO:

NDC Distribution & Logistics Center
MedPlus Services USA
407 New Sanford Road
La Vergne, TN 37086

LOSS/DAMAGE

1) All shrink-wrapped pallets must be inspected for obvious damage upon arrival. If any of the pallets arrive without the blue shrink wrap, top sheet, broken seal tape, or double stack label this MUST be noted on the drivers delivery receipt and signed by the driver. It should be assumed that pallets delivered in this manner will contain concealed damages or shortages. You can require the driver to stay while you verify the contents of the shipment and to look for damages in side the pallets.

2) Within 72 hours of receipt of shipment, Customer Service must be notified via the shipping discrepancy form. A copy of the delivery receipt, properly signed detailing any damages or shortages must be included.

3) Customer Service will acknowledge receipt of your discrepancy within 24 hours via fax.

4) Any request for credit or deduction taken from payment without the proper notation on the delivery receipt and acknowledged shipping discrepancy form can not be honored. Deduction taken without documentation will be charged back. Non response to chargeback can result in delay of orders.

REMIT TO ADDRESS

MedPlus Services USA
Dept 169 PO Box 37904
Charlotte, NC 28237-7904

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