Reseller Application

Please fax application to (803) 407-3819, or
e-mail application to info@activecaremed.com.

Legal Name of Business ______________________ Trade Name (DBA) ______________________

Billing Address ______________________ City ____________ State ______ Zip Code ____________

Shipping Address (if different) ______________________ City ____________ State ______ Zip Code ____________

Phone ______________________ Federal ID ______________________

Fax ______________ Company Web Address ______________ Duns ______________

Accounts Payable: Name ______________________ E-mail ______________________

Phone ______________________ Fax ______________________

Business Owner: Name ______________________ E-mail ______________________

Phone ______________________ Fax ______________________

Purchasing Agent: Name ______________________ E-mail ______________________

Phone ______________________ Fax ______________________

Type of Business	Medicare Provider Number	# of Employees	# of Years in Business
☐ Non-Profit ☐ Proprietorship ☐ C-Corporation ☐ S-Corporation ☐ Partnership ☐ LLC			

Is your company accredited by Medicare? ☐Yes ☐No If "No," is your company currently undergoing accreditation? ☐Yes ☐No

Note: Please include, with this application, a copy of documentation indicating your accreditation status. For assistance you may contact ActiveCare Medical at 866.621.4933.

Is your company a member of a buying group? ☐Yes ☐No If "Yes," please provide group name ______________________

PRINCIPALS/OWNERS INFORMATION

Your personal guaranty is required if: your company has less than $5MM in annual sales or revenues; is less than 2 years old; has fewer than 10 employees or; is a partnership or proprietorship. Giving us your personal guaranty will speed the process of approving your application especially if you have a small or young company. If we can't grant you credit on the basis of your company's information, you may be able to receive credit if you agree to be personally responsible for paying your company's account.

(1) Full Name ______________________ Title ______________________

Social Security ______________________ Date of Birth ______________________

Home Address ______________________ State of Residence ____________
Address City State ZIP

(2) Full Name ______________________ Title ______________________

Social Security ______________________ Date of Birth ______________________

Home Address ______________________ State of Residence ____________
Address City State ZIP

Have Owners or Principals ever filed Bankruptcy? ☐ Yes ☐ No

If yes, explain details: ______________________

PURCHASING/CREDIT REQUIREMENTS

Total Estimated Annual ActiveCare Purchases $ ______________ Amount of Credit Requested $ ______________

☐ IF OVER $10,000, CHECK BOX AND ATTACH CURRENT BALANCE SHEET AND INCOME STATEMENT

TRADE REFERENCES (List Three Major Vendors)

Trade Ref. __________________ Account No. _________________ Contact _______________________ Phone __________________

Trade Ref. __________________ Account No. _________________ Contact _______________________ Phone __________________

Trade Ref. __________________ Account No. _________________ Contact _______________________ Phone __________________

BANK REFERENCE

Bank Ref. __________________ Account No. _________________ Contact _______________________ Phone __________________

Address ____

TAX RESALE CERTIFICATION

☐ Tax Exempt – exempt from ActiveCare assessing your sales tax ☐ Multi-State Tax Exemption or one for each state shipped

Note: A valid resale certificate is required for all states in which you do business. Please list your "home state", and any additional states in which the "home state" resale certificate is not accepted. For assistance you may contact ActiveCare Medical at 866.621.4933.

HOME STATE - Please list the "home state" your company conducts business in: ____

ADDITIONAL STATES - Please list any additional states in which you transact business and submit a corresponding resale certificate if the resale certificate of the "home state" is not accepted. ____

INDEMNITY AGREEMENT

The dealer agrees to indemnify and hold harmless ActiveCare and its wholly owned subsidiaries and each of their successors and assigns from any and all claims, losses, damages, charges, expenses (including any and all reasonable expenses involving attorney's fees and product recall) which may be made against ActiveCare and its wholly owned subsidiaries and each of their successors and assigns or which ActiveCare and its wholly owned subsidiaries and each of their successors and assigns may incur arising out of any negligent actions of the dealer, including, but not limited to, the maintenance, repair, or alterations of any ActiveCare branded or sold product. Should the company sign and agree to this agreement, any and all guarantees, terms and conditions regarding indemnity contained on routine customer invoices shall be superseded and controlled by this document. The undersigned authorizes the suppliers, banking officers, attorneys, and accountants designated herein to disclose to ActiveCare and its wholly owned subsidiaries and each of their successors and assigns all information requested pertaining to the business entity and its officers or owners in the credit review and extension process.

STATEMENT

I hereby certify that the foregoing figures and statements contained herein and attached hereto are true and correct and are furnished to ActiveCare for the purpose of inducing said corporation to extend credit to the undersigned. I authorize ActiveCare to make inquiries as necessary into the company credit history of said owners including, but not limited to, credit bureaus or credit reporting agencies, to determine credit worthiness, and retain this data in its file for future references. Applicant agrees (1) To pay all charges within payment terms; (2) The balance owed will become due in full upon any default in payment or upon violation of the terms of any agreement with ActiveCare; (3) All late balances will be subject to a 1.5% finance charge; (4) To pay all collection costs including reasonable attorney fees. I hereby authorize ActiveCare to contact our bank and trade references for normal credit information.

I hereby understand and agree that ActiveCare may do the following regarding the information contained herein, from inquiries into company credit histories and company credit histories, and from orders/transactions (personal information): (1) share and maintain personal information electronically and/or in paper form between departments within ActiveCare; and (2) Share and maintain personal information electronically and/or in paper form with third parties for reasons of auditing, financial reporting, security, risk/fraud control, orders/transactions, outsourced services, debt collection, resolution of disputes, and as otherwise permitted or required by law.

SECURITY INTEREST

To secure payment for all purchases from ActiveCare, now and in the future, Debtor hereby grants ActiveCare a continuing security interest in all of Debtor's presently owned or hereafter (a) goods, (b) instruments, (c) Chattel paper, (d) books and records, (e) accounts, (f) accounts receivable, (g) general intangibles, and (h) payment intangibles and together with all proceeds and all support obligations thereof. The following constitute Customer defaults: Non-payment in timely fashion of Customer's indebtedness to ActiveCare bankruptcy, insolvency, or assignment for the benefit of creditors; misrepresentation in respect of any provision of this or any Agreement between ActiveCare and Customer. In the event of default ActiveCare may declare all unpaid balances due. Customer authorizes ActiveCare to file a financing statement describing the collateral.

PRINCIPAL'S SIGNATURE ____ DATE __________________________
Owner or CEO

PRINTED NAME OF PERSON SIGNING ___________________________________ TITLE _________________________

NOTE: CREDIT APPLICATION MUST BE SIGNED BY A PRINCIPAL (CEO OR OWNER) LISTED ON PAGE 1 OF THIS APPLICATION.