



DEALER/DISTRIBUTOR APPLICATION

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BUSINESS CONTACT INFORMATION

Name:		Title:	
Company name:		Company Type (e.g. store/online)	
Phone:	Fax:	E-mail:	
Registered company address:			
City:		State:	ZIP Code:
Date business commenced:		Reseller #	
Amazon Store Name:		EBay Seller ID:	
Type of Business (Corp, LLC, Sole Proprietor, etc.)			Website:

BUSINESS AND CREDIT INFORMATION

Primary PHYSICAL business address (NO PO BOXES):			
City:		State:	ZIP Code:
How Long at current address?		E-mail:	
Telephone:		Fax:	
Bank name:			
Bank address:		Phone:	
City:		State:	ZIP Code:
Type of account	Account number		
Savings			
Checking			
Credit Card # (REQUIRED)		Daily Limit on Card?	

BUSINESS/TRADE REFERENCES

Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			

AGREEMENT

1. All pricing includes a 3% discount for cash. All orders are to be prepaid with credit card for the 1st 3 weeks, followed by check draft/ACH in order for the cash discount to apply. By your signature below, you acknowledge and accept the terms and conditions of our current catalog, as referenced on our website www.hwhealth.com. The terms and conditions are subject to change at any time without prior notice.
2. Claims arising from invoices must be made within seven working days.
3. By submitting this application, you authorize Healthwise to make inquiries into the banking and business/trade references and agree to pay all invoices within Healthwise published terms, pay interest charges assessed on past due invoices, and agree to pay any and all reasonable fees incurred as a result of collecting past due amount or accounts in default. By your signature below you also agree to personally guarantee payment in the event of default.

SIGNATURES

Title:	Title:
Date:	Date:

**** PLEASE INCLUDE RESALE CERTIFICATE WITH APPLICATION**