



1875 N. Lakewood Dr. • Coeur d'Alene, ID 83814

Phone Orders: 800.333.7374

Fax Orders: 800.990.5285

Online Orders: Oxyfresh.com

24 hours a day • 7 days a week

Distributor Agreement Form (All information is confidential)

SS# / SI# or FEDERAL ID# / CORPORATE ID#
(Number under which Oxyfresh income should be reported, optional for Canadians.)

RESALE TAX# (if any)
(Exemption Certificate must be submitted to Oxyfresh. Contact Distributor Services.)

BUSINESS NAME, if applicable
(If the Oxyfresh Distributorship will be listed under a business name, the BUSINESS OWNER must be listed on the next line.)

COUNTY OF RESIDENCE

APPLICANT'S NAME (Last, First, Middle Initial)
Signature required below (If the Oxyfresh Distributorship will be listed under a business name, the BUSINESS OWNER must be listed here.)

PROF. TITLE

BIRTHDATE (MO/DAY)

APPLICANT OCCUPATION

APPLICANT EMAIL ADDRESS

HOME PHONE

BUSINESS PHONE

FAX

SPOUSE NAME if applicable (Last, First, Middle Initial)
Signature required below if Spouse is listed.

PROF. TITLE

BIRTHDATE (MO/DAY)

SPOUSE OCCUPATION

SPOUSE EMAIL ADDRESS

BILLING ADDRESS

CITY

STATE/PROVINCE

ZIP/POSTAL CODE

SHIPPING ADDRESS (We do not ship to P.O. Boxes)

CITY

STATE/PROVINCE

ZIP/POSTAL CODE

PRIMARY CONTACT PERSON'S NAME (Last, First, Middle Initial)

TITLE/POSITION

SPONSOR'S NAME (Last, First, Middle Initial)

SPONSOR'S OXYFRESH ID#

Enrollment Kit:

Payment Options (Choose One):

Please charge my One Year Enrollment with Enrollment Kit (\$50 US), \$250 Clinical Trial Pack (if applicable) + tax & shipping to the following:

- MASTERCARD DISCOVER PERSONAL CHECK (enclosed)
VISA AMEX DINER'S MONEY ORDER (enclosed)

CARD NUMBER CVV# EXP. DATE (MO/YR)

CARD HOLDER'S NAME

SIGNATURE

Terms and Conditions: By signing below, I hereby acknowledge that I have read and agree to the Oxyfresh.com Policies and Procedures. I also authorize Oxyfresh.com, to withdraw payment for Distributor Enrollment Fee from my credit card as identified in this Agreement.

E-mail options (Check all you wish to receive):

- BlissBusiness.com (recommended)
Leaders/Hotline Email (recommended)
Dental Group Email
Pet Group Email
Weight Loss & Nutrition Group Email

Applicant's Signature:
(required)

Date:

Spouse's Signature:
(required if listed above)

Date: