

XIMO HEALTH

DISTRIBUTOR APPLICATION AND AGREEMENT

Applicant Name (Last, First, Middle) or Business Name

Social Security or Business Tax ID Number

Mailing Address:

City\State\Country ZIP-Postal Code

Email:

Phone:

Cell:

Sponsor Information: Name:

XIMO ID:

Tel #

CHOOSE YOUR OPTIONAL PRODUCT PACKAGE

- | | |
|----------------------------------------------------------------------------------------------------------------------|---------------------|
| <input type="checkbox"/> XIMO Gold Pack 15 Bottles 16 oz | \$ 60 & \$10.99 s/h |
| <input type="checkbox"/> XIMO Capsules 90 ct bottle | \$ 45 & \$ 5.99 s/h |
| <input type="checkbox"/> XIMO (1 Bottle XIMO Capsules, 10 Sample Packs & 5 brochures) | \$ 60 & \$ 5.99 s/h |
| <input type="checkbox"/> XIMO Business Builder Package (15 drinks, 1 bottle capsules, 20 sample packs, 20 brochures) | \$145 & \$10.99 s/h |

Shipping and handling charges may exceed that listed above if delivery address is a P.O. Box.

AUTOSHIP PROGRAM

Check here to have your optional product package sent by autoship each month on your designated day:

Yes Autoship my package above on this date each month 1 8 15 22 28

I have read the terms and conditions on the back of this application and agreement, the XIMO Health Policies and Procedures, and the XIMO Health Compensation Plan, and agree to comply with these documents. I understand that I have the right to terminate my XIMO Health Independent Business by sending written notice to XIMO Health at the address below. I certify that my social security or business tax identification number written above is correct, that I am not subject to backup withholding tax, and that I am a United States Citizen.

I understand that any products purchased in connection with becoming a distributor are optional. I authorize the package selected above, shipping and handling, and autoship program purchase (if selected) to be charged to my credit card when due. I make this purchase pursuant to the terms and conditions of the credit card agreement for my card below.

VISA MasterCard American Express

Credit Card # _____ CCV _____ Expiration Date _____

Name on Card

Billing Address _____ City _____ ST _____

Applicant Signature _____ Date _____

Please fax back both pages of the completed and signed application and agreement to the fax number below.

XIMO HEALTH
1545 S 4800 W
Salt Lake City, Utah 84104
(801) 413-2844 Telephone
(801) 906-5458 Fax

You, the buyer, may cancel this transaction at any time prior to midnight of the third business day after the date of this transaction (five days for Alaska residents). See reverse side of this form for an explanation of this right.