KY Meds Inc. Customer Agreement

11381 Decimal Drive, Louisville KY 40299

Phone: 877-559-5963 Fax: 877-683-2065

** Copy of license(s) and DEA must be faxed or emailed **

Company Name (trade name if different)____

Address (Billing)________________________City________________State______Zip______________

Address (Ship To)________________________City________________State______Zip______________

Phone____________________Fax____________________Email____________________

State Lic#________________Exp______________State______(Please attach copy of license)

Type of Pharmacy: Retail/LTC/Specialty Center/Other____________________# of locations______________

Principal Officers and/or Partners

Name________________________________Title________________Tel____________________

Name________________________________Title________________Tel____________________

Purchasing Agent________________________A/P Contact________________________

Credit References

Primary Wholesaler____

Secondary Generic Supplier____

Bank Name________________________________Acct Number________________________

Address____________________City______________State______Zip__________Tell______________

We authorize you to check our company credit rating and verify the information provided in this credit application. By signing, using, or requesting issuance of credit by KY Meds Inc., we agree to the following:

1. This is an unconditional personal guarantee for all credit extended by KY Meds Inc or its subsidiaries in connection with the purchase of any and all goods. Further, the guarantor agrees to subject their company to the jurisdiction and venue of the Kentucky courts.
2. We understand our terms are Net 20 subject to credit approval and agree to pay at the place designated on the invoice all drafts and obligations, evidence of credit, and all extensions of credit, and all finance charges when imposed, either

a. In full upon due date or,

b. If not paid upon due date, a 1.5% monthly finance charge will be assessed

c. On default or failure to pay as agreed, you will pay to KY Meds Inc. or its subsidiaries collection costs, the maximum monthly finance charge permitted, and reasonable attorney's fees.

d. Customer agrees to pay a 20% restocking fee on all AUTHORIZED returns. No credit will be given to UNAUTHORIZED returns.

3. We hereby grant permission to KY Meds Inc. and its subsidiaries to send advertising and promotional materials to the email(s) and fax number(s) listed above. This operates as consent under the 47 U.S.C. § 227 of the Telephone Consumer Protection Act.
4. This agreement is binding on your representatives, successors, and assigns.

________________________________ ________________________

Signature of Principal/Guarantor Date

________________________________ ________________________

Printed Name Title

Submit Customer Agreement and Recurring Payment Authorization Form to:

Email: Sales@kymeds.com or Fax: 877-683-2065

Rep ________

Recurring Payment Authorization Form

Choose your preferred method of payment:

- ☐ Automatically debit checking account on invoice due date. (Net 30) If no selection is made, this choice will apply.
- ☐ Automatically debit credit card account on the invoice due date. (Net 30)

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount due. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided. Providing the information below grants you Net 30. However, payments made by check default to Net 20.

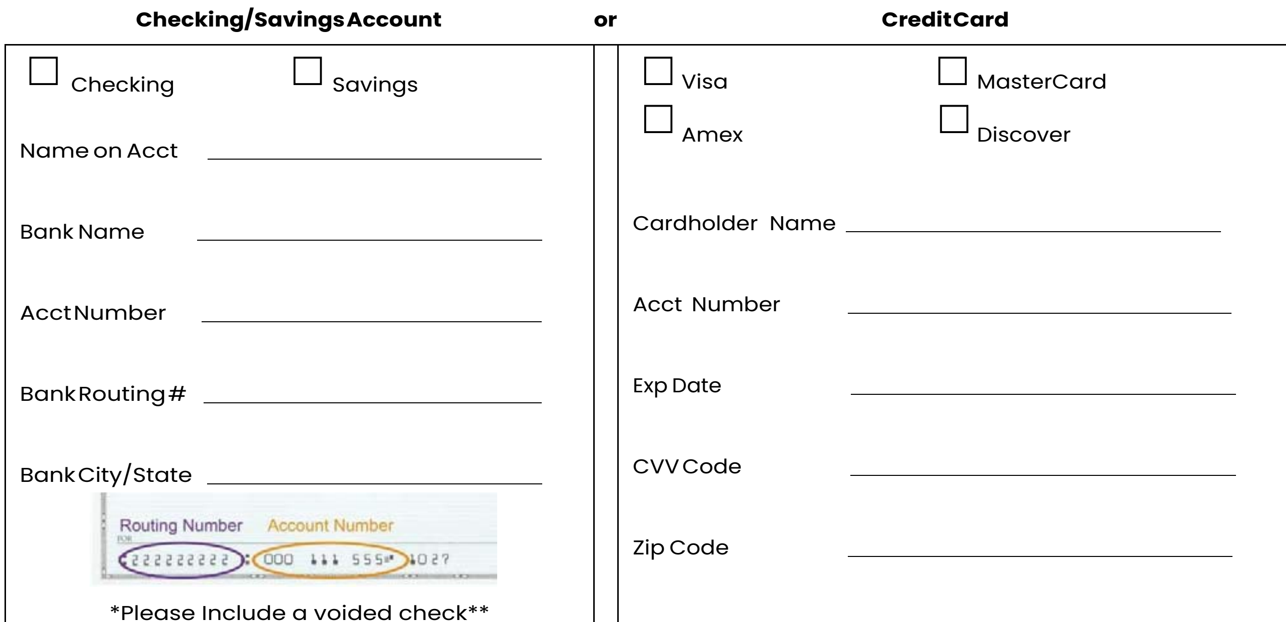
Please complete the information below:

I,____, authorize KY Meds, Inc. to charge my checking account or credit card indicated below for open invoices.

Company Name____

Billing Address____ Phone________________________________

City, State, Zip____ Email________________________________



Checking/Savings Account	or	**Credit Card**
☐ Checking ☐ Savings		☐ Visa ☐ MasterCard ☐ Amex ☐ Discover
Name on Acct ____________________		Cardholder Name ____________________
Bank Name ____________________		Acct Number ____________________
Acct Number ____________________		Exp Date ____________________
Bank Routing # ____________________		CVV Code ____________________
Bank City/State ____________________		Zip Code ____________________
Routing Number Account Number ⑆222222222⑆ 000 111 555⑈ 027		
*Please Include a voided check**		

Signature____Date ________________________________

Submit form to: robert@kymeds.com or Fax to 877-683-2065

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify KY Meds, Inc in writing of any changes in my account information or termination of this authorization. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form. Revised: Jan 2019