



UPNI Business Membership Enrollment Form

The UPNI Business Membership represents our way of appreciating your efforts in advancing community pharmacies. As a Business Member, you will have access to complimentary services and contract pricing at **no cost to you**. In order to facilitate your enrollment, please complete this form and mail or fax to:

United Pharmacists Network
801 N. Brand Blvd. Suite 330
Glendale, Ca. 91203
Fax: 818-549-2280

Pharmacy Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email Address:** _____

DEA #: _____ **NCPDP:** _____

NPI: _____ **Fed Tax ID:** _____

Owner or Contact Person: _____

Primary Wholesaler: _____ **Wholesaler Account #:** _____

_____ I am interested in signing up with The Harvard Drug Group, L.L.C. (d.b.a. Major Pharmaceuticals/
Initial Letco Medical/ Expert Med) as a secondary wholesaler with no obligations. Major Pharmaceuticals offers members of UPNI contract pricing for brand and generic medications.

Your complimentary Business Membership will support UPNI’s efforts to benefit independent community pharmacies, as we may receive rebates, administrative fees and promotional allowances from wholesalers, drug companies and/or other vendors as a result of your participation in this Buying Group Program.

To increase value for our members, UPNI and its business partners from time-to-time may send marketing materials that offer buying opportunities which we have negotiated on behalf of our members. I understand that I may opt out of this program by calling the UPNI office.

Signature: _____ **Date:** _____

Print Name: _____ **Title:** _____

UPNI Signature: _____ **Date:** _____

Print Name: _____ **Title:** _____

The Harvard Drug Group, L.L.C.
d/b/a Major Pharmaceuticals / Letco Medical / Expert Med

Credit Application

Acct # _____

Legal Name of Business: _____ **d/b/a** _____

Ship to Address: _____ City: _____ State: _____ ZIP: _____

Bill to Address: _____ City: _____ State: _____ ZIP: _____

Business Phone: _____ Fax: _____ E-mail: _____

Should we charge sales tax? Yes No (If No, give Tax I.D. Number & attach copy of Sales Tax Certificate) Tax I.D.: _____

Accounts Payable Manager: _____ Buyer's Name _____

Payment Option: ACH Draft; to be drafted on due date.

Send my Statements via: No Statement (pay by invoice) E-Mail Fax Have You Ever Filed for Bankruptcy? Yes No

Ownership: Sole Proprietor Partnership Corporation LLC; Years in Business: _____ **DUNS #:** _____ - _____ - _____

Owner: Name _____ SS # _____ - _____ - _____

Home Address _____ City _____ State _____ ZIP _____ Home Phone _____ - _____ - _____

Previous Account: No Yes If Yes, Account # _____

Bank Reference: Name of Bank: _____ Type of Account: _____

Banker: _____ Phone: _____ - _____ - _____ Account #: _____

Trade References:	Please list primary wholesaler on line one.		
NAME	ADDRESS/CITY/STATE/ZIP	ACCT #	TELEPHONE #
1. _____	_____	_____	(____) _____
2. _____	_____	_____	(____) _____
3. _____	_____	_____	(____) _____

The undersigned agrees to pay service charges of 1.5% per month or the highest lawful rate, whichever is lower on any past due balance, and all actual attorney fees and costs of collection; bank draft of account when account becomes delinquent.

I, _____ personally guarantee all payments of existing and future obligations and
(Print Name)

unconditionally waive the right to any amount paid pursuant to this provision. The undersigned also agrees to jurisdiction and venue in Michigan. The above statements are made for purposes of procuring credit from The Harvard Drug Group and its divisions and affiliates including Major Pharmaceuticals, Letco Medical and Expert Med ("company"). The undersigned hereby consents to the confirmation by company, of the information contained herein and authorizes company to contact the undersigned's bank and all credit references and obtain any necessary credit reports.

Terms of sale have been fully explained and I understand that if an account is established, my credit line is subject to periodic review. Also shipments may be held if my account is delinquent or exceeds my established line of credit. The undersigned further represents that its professional licenses are in good standing and not the subject of any proceedings by any governmental agency and agrees to notify the seller immediately upon the commencement of any such proceedings. The undersigned authorizes company to take appropriate measures in verifying the credit of the undersigned and releases company from any obligation while researching this information. Customer and Guarantor agree to provide company with 60 days notice of its intention to sell all of its assets. Special contract pricing is subject to verification of entitlement at any time after the sale and customer agrees to refund in the event there is no entitlement.

Signature of Guarantor: _____

_____ **Date**

Print Name: _____

PLEASE INCLUDE A COPY OF YOUR STATE BOARD AND DEA LICENSE AND SALE TAX EXEMPT (if applicable)

Calls to and from The Harvard Drug Group, its divisions and affiliates, may be monitored for quality assurance purposes. The Harvard Drug Group LLC, its divisions and affiliates, may from time to time, provide promotional information via phone, fax or e-mail to its customers. You may request to be removed from any of these channels by calling 1-800-875-0123 Ext. 2000 or you may send an e-mail to opt-out@harvarddruggroup.com

The Federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age; (provided the applicant has the capacity to enter into a binding contract); because all or part of the applicant's income derives from any public assistance program; or because the applicant has in good faith exercised any right under the Consumer Credit Protection Act. The federal agency that administers compliance with this law concerning this creditor is Federal Trade Commission, Equal Credit Opportunity, Washington, D.C. 20580. Revised 7/07/09



Purchasing Group Designation

Company Legal Name _____
DBA Name (if different) _____
Street Address _____
City, ST, Zip _____ Phone _____
State License # _____
DEA # _____

Anda, Inc. / VIP, Inc.
Division of Watson Pharmaceuticals, Inc.

_____ (Customer) is a current member of, and hereby designates _____ as the Customer's purchasing organization and is therefore entitled to receive any membership benefits that have been agreed upon with Anda/VIP under this primary designation.

Effective date of purchasing group membership _____

Please select Customer's primary class of Trade:

- | | |
|--|--|
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Physicians | <input type="checkbox"/> Hospital- In-Patient |
| <input type="checkbox"/> Government- Federal | <input type="checkbox"/> Senior Living |
| <input type="checkbox"/> Mail Order | <input type="checkbox"/> Hospital- Out-Patient |
| <input type="checkbox"/> Government- State | <input type="checkbox"/> Specialty/Infusion |
| <input type="checkbox"/> Repackager | <input type="checkbox"/> LTC Pharmacy |
| <input type="checkbox"/> Student Health | <input type="checkbox"/> Retail |
| <input type="checkbox"/> Chain-Non-Warehousing | <input type="checkbox"/> Chain-Warehousing |

Is Customer considered a closed door or alternate care pharmacy? Y___ N___

In order to qualify for special pricing from Anda/VIP, it is understood that Customer does not sell to conventional retail customers. Customer agrees to meet this requirement and will forfeit special pricing from Anda/VIP if Customer does not comply. If Customer has a change to their closed door or alternate care pharmacy status, notification will be sent to Anda/VIP in writing within 30 days.

Monthly Volume _____ bed or script count _____

Confidentiality Agreement

All information relating to the respective business and financial affairs of the customer and Anda/VIP, including but not limited to pricing and discounts, shall be kept in strict confidence by the other party hereto. The foregoing obligation does not apply to any information that has become publicly available, that is rightfully obtained from third parties who are not bound by any confidentiality requirement, or disclosures, which are required to be made under any state or federal law.

This designation shall supersede any and all previously executed Agreements with Anda/VIP, Inc. with respect to the subject matter hereof. Customer is permitted to change purchasing organization designation one time per quarter upon 30 days written notice to Anda/VIP

Customer Signature
Printed Name _____
Title _____
Date _____

Please fax signed form to (954) 217-4138