univera

CONVENIENCE PLAN CHANGE/ENROLL & ENROLLMENT PLAN AGREEMENT

FAX YOUR COMPLETED FORM TO (877) 627-4747 OR MAIL TO UNIVERA, 2660 WILLAMETTE DRIVE NE, LACEY, WA 98516.

DATE MONTH DAY YEAR

Univera ID Number

Last Name

First Name M.I.

BILLING ADDRESS (include Apt #, Box No, Suite, etc.)

City State

Zip + 4 -

SHIPPING ADDRESS IF DIFFERENT FROM ABOVE (include Apt #, Box No, Suite, etc.)

City State

Zip + 4 - County

E-mail Address (Univera uses this address to provide you valuable communications.)

Daytime Telephone - -

Evening Telephone - -

If changing your CP order:

☐ Please add these items to my existing order

☐ Please replace my current order with these items

Enrolling Associate

Enroller Last Name First Initial

Enroller Univera ID Number

ASSOCIATE AGREEMENT

I have read and accept all of the terms and conditions as outlined on the reverse side of this form and the Policies and Procedures manual. I understand that I have the right to terminate my distributorship at any time with or without reason. I agree that such termination must be in writing.

Associate Signature **Date**

Associate Signature (for Joint Associate if applicable) **Date**

CONVENIENCE PLAN AGREEMENT

I hereby authorize Univera, Inc., to charge my credit card, checking or savings account for the monthly Convenience Plan. I understand (i) automatic withdrawals from financial institutions will be posted each month and require up to five working days for verification of funds; (ii) any price changes reflected on the price list will be reflected on my Convenience Plan invoice; (iii) my participation is strictly voluntary and I will continue to receive products on a monthly basis to my designated shipping address; (iv) changes to or cancellation require 15 days written notice and must include my name, Univera ID and signature.

Please begin my CONVENIENCE PLAN on

MONTH ☐☐ **DAY** 1st ☐ 8th ☐ 15th ☐ 22nd ☐

Associate Signature **Date**

PAYMENT INFORMATION

☐ VISA ☐ MC ☐ DISC ☐ AMEX ☐ ACH (Requires attached void check)

Card Number **C.I.D. #**

Expiration Date /

Name on Card

Associate Signature **Date**

• ASSOCIATES ON CONVENIENCE PLAN USE WHOLESALE PRICING

CONVENIENCE PLAN STANDING ORDER - FOR MONTHLY SHIPMENTS

ITEM NUMBER	PRODUCT DESCRIPTION	QUANTITY	BV EACH	PRICE EACH	TOTAL QTY x BV	TOTAL QTY x PRICE
					TOTAL*	

*Shipping and handling charges and sales tax (if applicable) will be applied at the time your order is processed. Item #107150 V2(10.07)

Orders must be faxed two business days prior to your CP processing date.