

AutoShip details:

XtremeHealth Formulas offers Independent Distributors the opportunity to purchase customized product orders at wholesale prices with a minimum monthly order of \$49.95 (actual dollars spent AFTER discounts are applied). By taking advantage of this program, Distributors receive the convenience of having orders automatically shipped to home or office each month. In addition, this program assures that Distributors remain qualified for all benefits and bonuses as outlined in the XtremeHealth Formulas Policies and Procedures, Terms and Conditions, and the Compensation Plan.

I have carefully read and agree to all the terms and conditions pertaining to this agreement. I understand that this Agreement will remain in effect until I cancel this Agreement through one of the methods specified. The products I purchase are for my own use, and I agree that I will not resell any XtremeHealth Formulas products unless I am also an XtremeHealth Formulas Independent Distributor in good standing. I further understand that I may cancel this transaction at any time prior to midnight of the third business day after the date of this transaction. See reverse side of this form for an explanation of this right.

Yes! Enroll me on monthly AutoShip and send the following order each month:

Description	Qty.	Price	Amount
Maximizer AutoShip - 30 five capsule packets of our Energy Formulation		\$119.95	
Standard AutoShip - 10 five capsule packets of our Energy Formulation		\$49.95	
Note: XtremeHealth Formulas will calculate shipping based on standard USPS rates and process orders automatically. Allow 10 business days AFTER order is received.		Sub-total	
		CA sales tax 8.25%	
		TOTAL	

Signature _____ Date _____

Send AutoShip orders monthly on (choose one): 1st 8th 15th 22nd

Independent Distributor information:

First name _____ M.I. _____ Last name _____ Phone _____
 Company name (if applicable) _____ Cell or other phone _____
 Street address _____ Apt or suite number _____
 City _____ State _____ ZIP code _____ Email address _____

Billing information:

Visa / MasterCard / Amex / Discover Fill in all info. Sign and date below.

Card type _____ Card number _____ CSV (3 or 4 digits on back of card) _____
 Cardholder name as it appears on card _____ Expiration date _____
 Billing address assigned to card _____ Apt or suite number _____
 City _____ State _____ ZIP code _____

 Fax to XtremeHealth Formulas:
1-909-420-0270

Date _____ Signature _____