



Yes, I would like to participate and earn extra income by referring my clients to you for their prescription needs. I understand I will receive a 6% commission on all purchases by referred clients to your program.

Company Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Business Fax: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

Please complete and fax to 888-820-8033

Agent ID# \_\_\_\_\_ (Assigned by MVC)

Marketed Nationally By:



IMGA Financial  
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