Flawless Health Inc, Affiliate Application

PLEASE TYPE OR PRINT

N A M E : _____

(Last Name) (First Name) (MI)

SOCIAL SECURITY NO:_____**DATE OF BIRTH**:_____ **GENDER** _____

S P O U S E ' S NAME:_____

(Last Name) (First Name) (MI)

SPOUSE'S SOCIAL SECURITY NO:_____

B U S I N E S S NAME:_____

Federal Tax I.D. #:___-_____

ADDRESS:_____

CITY:_____**COUNTY**:_____ **STATE**:_____ **ZIP**: _____-_____

E - M A I L ADDRESS:_____

TELEPHONE: (Home)_____

BUSINESS:_____

CELL:_____

FAX:_____

IF YOU ARE A HEALTH PROFESSIONAL, STATE YOUR SPECIALTY:_____

NAME OF SPONSOR:_____ FIN OR SS #:_____

APPLICANT ACKNOWLEDGMENT

We make no claims to prevent cure or treat any illness whatsoever. We do not make any income claims.

I hereby acknowledge that I have read this Flawless Health, Inc. Affiliate Application. I agree to indemnify and hold Flawless Health, Inc. harmless against any claims, costs, damages, losses, liabilities or expenses (including attorneys fees) arising from or connected with, directly or indirectly, any breach of this Agreement or other conduct by me, my agent or employee.

Independent Representative Applicant:_____Date: _____

Sponsor:_____Date: _____

COMMISSIONS:

- As an Affiliate on retail sales there will be a 30% over ride of retail price
- If you sponsor another affiliate you will be receiving a 12% override

The payment of $25.00 application fee will be made as indicated below:

Check Credit Card

Visa/MasterCard/Amex:_____ Exp Date:_____