Member Application

(Office use only)

Member #:______________ Dues:____________ Member Service Rep:__________________ Start Date:________

I wish to join the following VGM Group company(ies): ○ VGM ○ U.S. Rehab ○ Home Infusion ○ AHIA

Please print clearly and complete all fields:

Legal Company Name:____________________________________ DBA:________________________________

Health System/Hospital: ○ Yes ○ No

Mailing Address:____________________________ City:______________ State:_____ ZIP code: ____________

Phone:_____________________________________ Fax:____

Toll-free Phone:_____________________________ Business Hours:____________________________________

Owner's Name:____ Email:_____________________________

Owner's Name:____ Email:_____________________________

Store Contact (if different than owner):__________________________ Email:_____________________________

Key Contact:____ Email:_____________________________

Purchasing Contact:____ Email:_____________________________

Federal Tax ID#:______________________________ Medicare#:____________________________________

NPI#:____ Medicaid#:____________________________________

Bond Renewal Date:______________

If different than above, please include the following:

Shipping Address:____

Billing Address:____

Remit Address:____

Do you have any branch stores? ○ Yes ○ No If yes, total number of branch stores:_________________

****Please include additional branch locations on back page.***

Number of employees:___________ Years in business:____________ Est. annual revenue:__________________

List your top 5 product vendors and approximate annual volume with each:

1.______________________ Annual volume:______________ 4.____________________ Annual volume:______________

2.______________________ Annual volume:______________ 5.____________________ Annual volume:______________

3.______________________ Annual volume:______________

Accounts payable contact person at your company:____

Do you currently belong to any group purchasing organization (GPO)? ○ Yes ○ No

If yes, what organization?____

Please list all memberships in state associations:____

Website address:____

Liability insurance carrier?____________________________________ Renewal Date:_____________________

Currect Limits (optional):____

Accreditation and certification

Please specify your professional accreditation organization:

○ ACHC ○ CHAPS ○ HQAA ○ JCAHO ○ Other:____

Credentialed employees: *(check all that apply)*

○ CEAC ○ ATP ○ SMS ○ RRT ○ CRTS ○ PSGT ○ RPH ○ RN ○ LPN

Patient Travel Coordinator:_______________________ Phone (direct line):___________________________

How did you hear about VGM? Please be specific:____

____

____

Reasons for joining:____

____

____

____

What products or services do you provide? *(Please check all that apply)*

- Wheelchairs
- Custom rehab
- Ramps (rental)
- Ramps (built)
- Stair lifts
- Porch lifts
- Ceiling lifts
- Elevators
- Grab bars (install)
- Bath remodels
- Kitchen remodels
- ECUs (environmental control units)
- Wheelchair/scooter lifts
- Vehicle modifications
- Bariatric supplies
- Infusion services
- Beds
- Low air loss therapy
- Patient supports
- Patient lifts
- Enteral nutrition
- CPMs
- Phototherapy
- Electrotherapy
- Diabetic supplies
- Diabetic shoes
- Retail pharmacy
- Lymphedema pumps
- Ostomy/colostomy
- Wound care
- Incontinence supplies
- Conversion vans
- Oxygen concentrators
- Liquid oxygen
- Gaseous oxygen
- Transfilling concentrators
- Portable oxygen concentrators (POC)
- Respiratory meds/nebs
- CPAP/Bi-PAP
- Apnea monitors (infant)
- Volume ventilators
- Sleep labs
- Unattended sleep testing
- Orthotics/prosthetics
- IV therapy
- Home health services
- Breast pumps

I understand that my dues will be_______per month and that ***I must stay current (30 days)*** or will be subject to cancellation.

You warrant the information on or relating to this application is accurate, true and complete, and you will notify us of any material change to such information. We comply with Section 326 of the USA Patriot Act, which mandates that we verify certain information about you while processing your account application. You hereby authorize any bank, financial institution or trade reference listed herein to release usual and customary business or personal credit information to VGM. You also authorize us to offset any sums due from any of our affiliated companies, including but not limited to HOMELINK®, against any unpaid sums you owe us, our affiliated companies, without notice. You hereby waive any and all claims for payment of any offset made and also release HOMELINK from any and all claims or liability for said payment. You understand that we enter into contracts with certain vendors to obtain discounted pricing for VGM members, and that such vendors may pay a fee to VGM of up to three percent of the price of goods you purchase from the vendor. A copy of this signed authorization shall be deemed an original for all purposes. VGM reserves the right to refuse any applicant.

By signing up for VGM membership, you are opting in to receive our email messages, including industry articles, HME blog columns, legislative updates and savings opportunities. Opt out options are available at the footer of every email message.

Owner's Signature:____Date:____________________________

VGM Associate: ____Date:____________________________

For office use only: 02 08 16 LK; 02 09 16 LK

VGM GROUP INC.

PO Box 2817 | Waterloo, IA 50704
Phone: (800) 642-6065 | Fax: (800) 226-6191 |
www.vgm.com

NEW MEMBER PAYMENT AUTHORIZATION FORM

VGM #: _______________ COMPANY NAME: ____

CHECK ONE OPTION:

☐ I (we) wish to have VGM Group Inc. charge my ☐ electronic debit (ACH) or ☐ credit card or for the first month's membership dues ONLY. I (we) prefer to pay future invoices with another payment method.

☐ I (we) wish to have VGM Group Inc. charge my ☐ electronic debit (ACH) or ☐ credit card or for the first month's membership. I (we) will also be enrolling in reoccurring payments that will be processed on a monthly basis as indicated below.

COMPLETE IF AUTHORIZING ACH PAYMENT(S):

I (we) authorize VGM Group ("COMPANY") to initiate once each MONTH an electronic debit in the amount of $___________________ beginning in the month/year of ________________________ on the ☐ 6th ☐ 15th or ☐ 25th day of each month (check one) from my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debits) as follows at the depository financial institution named below ("DEPOSITORY"):

Check One: ☐ Checking Account ☐ Savings Account**** ☐ Share Draft

****If a SAVINGS account will be used for automatic withdrawal of the payment, please have the bank send VGM Group Inc. a signed statement that they will honor the "automatic withdrawal" when it is presented for payment.**

Depository (Financial Institution) Name: ____

Routing Number: _______________________________ Account Number: ____

!! NEED COPY OF VOIDED CHECK !!

COMPLETE IF AUTHORIZING CREDIT CARD PAYMENT(S):

VISA MasterCard AMERICAN EXPRESS

Credit Card# ____

Expiration Date: _________________________________**CVC/CVC2 code:** ___________

I (we) hereby authorize VGM Group Inc. to charge the indicated credit card $_____________ (plus any applicable tax beginning in the month of ___________ on the ☐1st, ☐10th, or ☐20th day of each month (check one).

Information as it appears on the card: CARDHOLDER NAME: ___________________________________

STREET ADDRESS: ____________________________________ CITY, STATE & ZIP: ____________________________________

Name(s) (Please Print) ____

Signature(s) ____ **Date**_________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify VGM Group Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the transaction is processed. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.