

Simply Natural Rx, Inc. Policies and Procedures Agreement

If you are a member of the Vibrant Health Community you can contact your Coach for assistance in any matters concerning your Simply Natural Rx (SNRx) account. Your Coach is authorized with SNRx to conduct business on your behalf.

If you are an automatic order client of SNRx directly, then your products are being produced up to 60 days in advanced of your receiving them. Continual production insures you get the freshest product available. This provides enough time to get your specific products designed, made and shipped to you with no interruption of your program. For this reason, you are required to notify SNRx in writing, via certified mail, a full 30 days in advance of any changes, delays or cancellation. If your notification reaches SNRx after the 30 day required notification there will be a 20% cancellation fee, as the process has already begun. If your products have already shipped then there is a 30% cancellation fee, along with shipping and handling charges both directions of \$32.00. If you refuse the shipment then there is an additional \$15.00 fee charged. Credits are not issued until the proper paperwork is received authorizing the cancellation, delay or change.

If you are a SNRx direct Customer no product returns, changes, or credits will be issued without the proper documentation and authorization by you. Please print the attached form and follow the instructions to make changes to your account.

Fill out the form and mail it, via certified mail, to this address:

Simply Natural Rx
370 South Lowe Ave. Ste. A
PO Box 163
Cookeville, TN 38501
(print)

Name: _____

Address: _____

City: _____ ST _____ ZIP _____

Telephone No. _____ E-Mail Address _____

- Delay my next order until _____
- Cancel my automatic order 30 days from receipt of certified mail of this notice
- I'd like to change my order to _____

Reason for change *** This item is required to process your request. If you physician recommended you stop products, then you need a copy of your medical record note, with his/her signature – name, address and phone number, to accompany this form.

I understand and agree to the charges in this agreement.

Signature

Date

Please credit the following Account No.

Credit Card or Debit Card No. or Check Routing and Account No. EXP CC