



Yes, you can.®

INVACARE CORPORATION

New Customer
 Change of Ownership

Customer Credit Application

*Legal Name of Business		Trade Name (DBA)	
*Billing Address:			
Shipping Address (if different):			
*Federal Tax ID #		* # of Years in Business	
*Phone	*Fax	Website	
*State of Incorporation or registration: _____		Duns Number: _____	
* Corporation <input type="checkbox"/> General Partnership <input type="checkbox"/> Limited Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Non Profit <input type="checkbox"/> Other _____			

Accounts Payable: Name _____	Email: _____
Phone: _____	Fax: _____
Business Owner: Name: _____	Email: _____
Phone: _____	Fax: _____
Purchasing Agent: Name: _____	Email: _____
Phone: _____	Fax: _____

I would like to receive product and service updates from Invacare: Yes ___ No ___ Email ___ Fax ___ (choose one)

What best describes your business?

DME _____% Pharmacy _____% Rehab _____% Respiratory _____%

Retail _____% Service Only _____% Wholesaler _____% Other _____%

***PRINCIPALS/OWNERS INFORMATION**

(1) Full Name _____ Title _____
 Social Security # _____ Date of Birth _____
 Home Address _____ State of Residence _____

(2) Full Name _____ Title _____
 Social Security # _____ Date of Birth _____
 Home Address _____ State of Residence _____

* Have Owners or Principals ever Filed Bankruptcy? NO YES
 (If yes, explain details) _____

*ACCREDITATION	
Is your business accredited? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date accredited and by which accrediting agency?	Percentage of Medicare Purchases % _____ Percentage of Medicaid Purchases % _____

BANK REFERENCE	
Bank Name	Address:
Contact Name and Phone:	Account #

*LOANS				
Do you have any outstanding Loans? Yes <input type="checkbox"/> No <input type="checkbox"/>				
If yes, please itemize below				
Name of Lending Party	Address	Phone	Contact	Balance of Loan

***AFFILIATIONS**

Is there an affiliated organization that has or had an account with Invacare and/or is you affiliated with another organization?
 NO YES If yes, please specify below:

Invacare Account Number: _____

Company Name _____ Address _____ City _____ State _____ Zip _____

What is the nature of the relationship? _____ Do they guarantee payment? Yes No

<p>*TAX RESALE CERTIFICATION HOME STATE Please enter the home state your company conducts business in _____</p>
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Note: A valid resale certificate is required for all states in which you do business. A signed resale certificate must be submitted with the application for your "home state", and any additional states in which you transact business in. For assistance you may contact CRM at 800-221-1559 x2238

<p>PURCHASING/CREDIT REQUIREMENTS Amount of Credit Requested \$ _____</p>	<p>Total Estimated Annual Invacare Purchases \$ _____ If over \$20,000 attach current balance sheet and income statement</p>
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INDEMNITY AGREEMENT

The dealer agrees to indemnify and hold harmless Invacare and its wholly owned subsidiaries and each of their successors and assigns from any and all claims, losses, damages, charges, expenses (including any and all reasonable expenses involving attorney's fees and product recall) which may be made against Invacare and its wholly owned subsidiaries and each of their successors and assigns or which Invacare and its wholly owned subsidiaries and each of their successors and assigns may incur arising out of any negligent actions of the dealer, including, but not limited to, the maintenance, repair, or alterations of any Invacare branded or sold product. Should the dealer sign and agree to this agreement, any and all guarantees, terms and conditions regarding indemnity contained on routine customer invoices shall be superseded and controlled by this document.

CERTIFICATION OF TRUTHFULNESS & ACCURACY BY APPLICANT, AGREEMENT TO PAY & CONSENT TO CREDIT INQUIRIES! I hereby certify that the foregoing figures and statements contained herein and attached hereto are true and correct and are furnished to Invacare for the purpose of inducing said corporation to extend credit to the undersigned. I authorize Invacare to make inquiries as necessary into the personal credit history of said owners including but not limited to credit bureaus or credit reporting agencies, to determine credit worthiness, and retain this data in its file for future reference. Applicant agrees (1) To pay all charges within payment terms (2) The balance owed will become due in full upon any default in payment or upon violation of the terms of any agreement with Invacare (3) To pay all collection costs including all reasonable attorney fees. I hereby authorize Invacare to contact our bank and trade references for normal credit information. The undersigned authorizes the suppliers, banking officers, attorneys, and accountants designated herein to disclose to Invacare and its wholly owned subsidiaries and each of their successors and assigns all information requested pertaining to the business entity and its officers or owners in the credit review and extension process.

I hereby understand and agree that Invacare may do the following regarding the information contained herein, from inquiries into personal credit histories and company credit histories, and from orders/transactions ("personal information"): (1) share and maintain personal information electronically and/or in paper form between departments within Invacare; and (2) share and maintain personal information electronically and/or in paper form with third parties for reasons of auditing, financial reporting, security, risk/fraud control, orders/transactions, outsourced services, debt collection, resolution of disputes, and as otherwise permitted or required by law.

* _____
 PRINCIPAL'S SIGNATURE DATE

* _____
 PRINTED NAME OF PERSON SIGNING TITLE

Note: Credit application *must* be signed by a **principal** or **owner** listed on **page # 1** of this application
 (*) **Asterisked fields are required fields.** Please note that additional fields may be required for processing.

(Office Use Only)

Revised 05/04/10

INVACARE AUTHORIZATIONS

TBM Signature _____ Terr. # _____ Date _____



Yes, you can.®

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (“BAA”) effective on the last signature date below, is entered into by and between Invacare Corporation (“Business Associate”) and _____ (“Covered Entity”).

1. BACKGROUND AND PURPOSE.

The Parties have entered into, and may in the future enter into, one or more written agreements, that require Business Associate to be provided with, to have access to, and/or to create Protected Health Information (the “Underlying Contract(s)”), that is subject to the federal regulations issued pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”) and codified at 45 C.F.R. parts 160 and 164 (“HIPAA Regulations”). This BAA shall supplement and/or amend each of the Underlying Contract(s) only with respect to Business Associate’s Use, Disclosure, and creation of PHI under the Underlying Contract(s) to allow Covered Entity to comply with sections 164.502(e) and 164.314(a)(2)(i) of the HIPAA Regulations. Business Associate acknowledges that effective January 1, 2010, it is responsible to comply with the HIPAA Security and Privacy regulations pursuant to Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH), including Sections 164.308, 164.310, 164.312 and 164.316 of title 45 of the Code of Federal Regulations. Except as so supplemented and/or amended, the terms of the Underlying Contract(s) shall continue unchanged and shall apply with full force and effect to govern the matters addressed in this BAA and in each of the Underlying Contract(s).

2. DEFINITIONS.

Unless otherwise defined in this BAA, all capitalized terms used in this BAA have the meanings ascribed in the HIPAA Regulations, provided, however, that “PHI” and “ePHI” shall mean Protected Health Information and Electronic Protected Health Information, respectively, as defined in 45 C.F.R. § 160.103, limited to the information Business Associate received from or created or received on behalf of Covered Entity as Covered Entity’s Business Associate. “Administrative Safeguards” shall have the same meaning as the term “administrative safeguards” in 45 C.F.R. § 164.304, with the exception that it shall apply to the management of the conduct of Business Associate’s workforce, not Covered Entity’s workforce, in relation to the protection of that information.

