

OOGP New Account Application

Sales Consultant Name **(REQUIRED)** _____

OWNER MUST COMPLETE & SIGN THIS APPLICATION.

THIS AGREEMENT is entered into this _____ day of _____, 20____, between _____ (hereinafter referred to as "Member") and OOGP.

Member agrees to participate in OOGP according to the terms and conditions set forth below:

1. To become a member of OOGP, the prospective member must be a licensed Eyecare Provider. OOGP reserves the right to obtain a written or oral report from any credit agency. Thereafter, the prospective member will be approved or disapproved by OOGP. If approved, an opening credit limit will be established.
2. The primary purpose of OOGP is to provide members an opportunity to utilize the benefits of volume and/or wholesale product purchasing. The Member, however, is free to purchase supplies or lab services from whatever source it desires, regardless of whether that source participates in OOGP.
3. Each participating buying group supplier will be authorized to invoice OOGP for the Member's purchases. The Member will place orders directly to the supplier by using an assigned "ship-to" number, and instruct the supplier to mail the materials directly to the Member's office. A copy of the invoice will be mailed to OOGP for billing.
4. The Member agrees to deal directly with each buying group supplier regarding any returns, credits or complaints.
5. The Member will be entitled to receive the published buying group discounts from OOGP.
6. Statements must be paid in full by the Member by the fifteenth (15th) of each month. Otherwise, your entire discount amount will be lost, or a 1.5% finance charge (18% annually, \$20 minimum) will be charged, whichever is greater, if payment is not received by the 15th. In addition, your account will be placed on credit hold with OOGP Distributing. If payment is still not received by the 25th, your buying group accounts will be placed on credit hold. If payment has not been made by the end of the month, the membership will be turned over to our collection agency and closed.
7. *If your business resides in a state that requires sales tax to be collected, a sales tax exemption (re-sale) certificate must be submitted in order to make tax-free purchases of items and services that are taxable. If you have a certificate you would like for us to put on file please fax a copy to (541) 476-8753 or email to patricia@oogp.com.*
8. For those members who have failed to comply with the payment policy on two separate occasions, OOGP reserves the right to place delinquent accounts on credit hold with buying group suppliers and OOGP Distributing on the 15th of the month or earlier if necessary.
9. If the account is turned over for collection, the member will pay a reasonable attorney and collections fee.
10. OOGP reserves the right to charge a fee for each returned check.
11. This Agreement is for an indefinite term but may be terminated by OOGP for breach of this contract, at any time.
12. The Member will hold OOGP harmless and indemnify against product liability claims that may be brought against OOGP in connection with any supplies or lab services purchased by the Member through OOGP.
13. This Agreement shall be governed by the laws of OREGON and items listed on Agreement shall not be modified unless published in writing.

Member Name (Please Print): _____ Title _____ Date: _____

Account Name: _____ Method to send statement:

Fax Email

Address: _____ (No hard copies will be sent)

City: _____ State: _____ Zip: _____ Billing/Stmt Email: _____

Phone: _____ Fax: _____ License # _____

Sole Proprietorship _____ Partnership _____ Corporation _____ Anticipated Monthly Purchase Amount: _____

Doctor/ Off Mgr: _____ Frame Purchaser: _____ Cont. Lens Purchaser: _____

Email: _____ Email: _____ Email: _____

Soc. Sec. #: _____ REQUIRED

Tax ID#: _____ REQUIRED

Do you belong to a Doctor Alliance Group? If yes, please list below: _____

BANK REFERENCE:

Name of Bank _____ Account Number _____

Bank Contact _____ Phone Number _____

I understand and agree to the above terms. I hereby assume personal responsibility for payment to OOGP regardless of whatever entity may place orders using this credit availability.

Owner Signature: _____ (Must Be Owner)

Revised 9/6/2016

Buying Group Account Transfer List



Please include the current account number of the suppliers you wish to bill through OOGP. If you do not have an existing account, please contact the supplier to establish your account. Upon your initial order, please remind the supplier that you wish to have your account billed through OOGP Buying Group. Return by fax, mail or email.

FRAMES:

A&A OPTICAL _____
 AREA 98 _____
 ASPEX _____
 ALTAIR EYEWEAR _____
 BRILLEN EYES _____
CHARMANT GROUP* _____
 CLARITI _____
 CLASSIQUE _____
CLEARVISION * _____
 DE RIGO _____
 DESIGN GALLERY _____
 EASTERN STATES OPTICAL _____
 EUROPA INT'L _____
 FGX, INC _____
 I OPTICS _____
 IMAGEWEAR _____
 INFACE COMPANY _____
 JONATHAN CATE _____
 KENMARK GROUP _____
L'AMY* _____
 LAFONT _____
 LEGRE EYEWEAR _____
 LOGO _____
LUXOTTICA* _____
 THE McGEE GROUP _____
 MARCHON _____
 MATCH EYEWEAR _____
MARCOLIN* _____
 MENIZZI ITALY _____
 MODERN OPTICAL _____
 MODO EYEWEAR _____
 MONDOTTICA USA _____
 MOREL EYEWEAR _____
 NEW YORK EYE _____
 NOUVEAU EYEWEAR _____
 POETS EYEWEAR _____

PRO DESIGN EYEWEAR _____
 REFLECT EYES _____
 REM EYEWEAR _____
 REVOLUTION _____
 SAFILO _____
SEIKO OPTICAL* _____
 SIGNATURE _____
 SILHOUETTE _____
 SMITH OPTICS _____
 SYMMETRY _____
 TURA _____
 VIVA _____
 WILEY X _____
 WOOW EYEWEAR _____
 ZIG EYEWEAR _____
 ZYLOWARE _____
OPTICAL ACCESSORIES: _____
 AMCON _____
 ARCH CROWN _____
 CA ACCESSORIES _____
 COSTA DEL MAR _____
 HILCO _____
 OPTISOURCE (CHEMICALS) _____
 RON'S OPTICAL CASE _____
OPHTHALMIC LABS: _____
 BEST PRICE DIGITAL LENSES _____
 CARL ZEISS _____
 CENTRAL OPTICAL LAB _____
 DYNAMIC LAB _____
ESSILOR LABS*: _____
 LAB _____
 ACCT # _____
 LAB _____
 ACCT # _____
 LAB _____
 ACCT # _____

HOYA: _____
 LAB _____
 ACCT # _____
 LAB _____
 ACCT # _____
 LAB _____
 ACCT # _____
NASSAU VISION * _____
 PECH OPTICAL _____
 WALMAN OPTICAL _____
STOCK LENSES: _____
 NASSAU VISION _____
PENTAX* _____
GP CONTACTS: _____
ESSILOR LABS*: _____
 LAB _____
 ACCT # _____
 LAB _____
 ACCT # _____
 LAB _____
 ACCT # _____
 FAR WEST OPTICAL _____
 VALLEY CONTAX _____
 X-CEL CONTACTS _____
SOFT CONTACT LENSES: _____
 ALCON _____
 COOPERVISION _____
 POLYVUE _____
PRACTICE SOFTWARE: _____
 REIMBURSEMENT PLUS _____
 REVOLUTION EHR _____
 VISION SOFTWARE _____

Revised 9/6/2016

**Premium Vendor partner. Please refer to our Premium Vendor sheet to learn more about saving up to an additional 10% and receiving money back when you order from select vendors.*

I, the undersigned do hereby authorize OOGP to transfer my accounts for the
 aforementioned suppliers to the OOGP buying group.

Contact Person _____
 Purchasing Agent

Name _____

Address _____

Signature _____

City/State _____

Phone _____ Date _____

Fax _____