



# David A. Crofts & Associates Inc.

LIFE • HEALTH • GROUP • INVESTMENTS  
AUTO • HOME • BUSINESS

422 Montague Ave. Suite 7 • Greenwood, SC 29649-1961

**Please return, by FAX or mail to:**

**David A. Crofts & Associates, Inc.**

**422 Montague Avenue, Suite #7**

**Greenwood, SC 29649**

**800-803-7873 -or- 864-223-8788**

**Fax: 864-229-7392**

Please note that most areas which require signatures are pointed out with markers such as these:





# LIFELINE

## DIABETIC AND MOBILITY

877-431-0808

**Medicare  
Approved  
Products at no  
cost to you!**

- Diabetic Testing Supplies
- Power Wheelchairs and Scooters
- Seat/Back Cushions
- Back Braces
- Shoulder Braces
- Up-lift Seats
- Vacuum Therapy
- Circulating Heating/Cooling Pads
- Gel Mattress Overlay



**Gel  
Mattress Overlay**



**Uplift Seat**



the  
Catalina



**Back Brace**



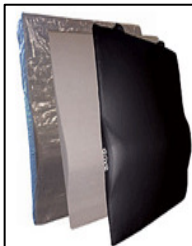
**Vital Wrap Circulating  
Heating/Cooling  
System**



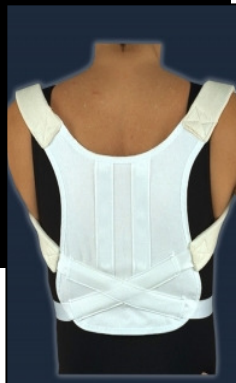
**Encore Vacuum  
Therapy  
Erection System**



**Advocate  
Talking Blood  
Glucose Meter**



**Seat/Back  
Cushions  
For wheelchairs**



**Shoulder  
Brace**

**PHONE 866-558-8557**

**FAX 888-918-2226**

**PATIENT INFORMATION**

**Patients Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Ship To Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Telephone** \_\_\_\_\_ **E-mail** \_\_\_\_\_ **Male** \_\_\_\_ **Female** \_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**

Medicare Claim Number \_\_\_\_\_

**Name as written on Red/White/Blue Medicare Card:**  
\_\_\_\_\_

**Secondary Insurance**

Does the patient have secondary insurance? \_\_\_\_\_

Insurance Company \_\_\_\_\_

ID number \_\_\_\_\_

Effect. Date: \_\_\_\_\_

**PRESCRIBING PHYSICIAN INFORMATION**

**Name** \_\_\_\_\_ **Clinic** \_\_\_\_\_

**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Fax** \_\_\_\_\_ **Date of Last Visit** \_\_\_\_\_

**NPI#** \_\_\_\_\_ **UPIN** \_\_\_\_\_

**MEDICAID #** \_\_\_\_\_

**Electronic Up Lift Seat**



*My signature authorizes each of the following:*  
 Assignment of Medicare, Medicaid or other insurance benefits to Lifeline and/or any of its affiliates for supplies furnished to me by Lifeline.  
 Direct Billing to Medicare, Medicaid or other insurers. I agree to pay for services provided to me or requested by me or on my behalf that are not paid by my insurance company or any other party responsible for payment of my supplies.  
 Release of my medical information to Medicare, Medicaid or any other insurer and their agents and assigns.  
 Lifeline and/or any of its affiliates to contact me by telephone or mail regarding my medical supplies and/or medications order.  
 I have received the Customer Service Rights Information, Return Policy, and the CMS Medicare Supplier Standards.

\_\_\_\_\_ SIGN HERE  
 CUSTOMER SIGNATURE DATE

\_\_\_\_\_ SIGN HERE  
 AGENT SIGNATURE DATE

**PHONE 866-558-8557**

**FAX 888-918-2226**

**PATIENT INFORMATION**

**Patients Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Ship To Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Telephone** \_\_\_\_\_ **E-mail** \_\_\_\_\_ **Male** \_\_\_\_ **Female** \_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**

Medicare Claim Number \_\_\_\_\_

**Name as written on Red/White/Blue Medicare Card:**  
\_\_\_\_\_

**Secondary Insurance**

Does the patient have secondary insurance? \_\_\_\_\_

Insurance Company \_\_\_\_\_  
 ID number \_\_\_\_\_  
 Effect. Date: \_\_\_\_\_

**PRESCRIBING PHYSICIAN INFORMATION**

**Name** \_\_\_\_\_ **Clinic** \_\_\_\_\_  
**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Telephone** \_\_\_\_\_ **Fax** \_\_\_\_\_ **Date of Last Visit** \_\_\_\_\_  
**NPI#** \_\_\_\_\_ **UPIN** \_\_\_\_\_  
**MEDICAID #** \_\_\_\_\_

**Gel Mattress Overlay**



***My signature authorizes each of the following:***  
 Assignment of Medicare, Medicaid or other insurance benefits to Lifeline and/or any of its affiliates for supplies furnished to me by Lifeline.  
 Direct Billing to Medicare, Medicaid or other insurers. I agree to pay for services provided to me or requested by me or on my behalf that are not paid by my insurance company or any other party responsible for payment of my supplies.  
 Release of my medical information to Medicare, Medicaid or any other insurer and their agents and assigns.  
 Lifeline and/or any of its affiliates to contact me by telephone or mail regarding my medical supplies and/or medications order.  
 I have received the Customer Service Rights Information, Return Policy, and the CMS Medicare Supplier Standards.

\_\_\_\_\_ SIGN HERE \_\_\_\_\_ SIGN HERE \_\_\_\_\_  
**CUSTOMER SIGNATURE**                      **DATE**                      **AGENT SIGNATURE**                      **DATE**

# LIFELINE *Diabetic and Mobility*

MOBILITY AIDS

**PHONE 866-558-8557**

**FAX 888-918-2226**

**PATIENT INFORMATION**

**Patients Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Ship To Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Telephone** \_\_\_\_\_ **E-mail** \_\_\_\_\_ **Male** \_\_\_\_\_ **Female** \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**

Medicare Claim Number \_\_\_\_\_

**Name as written on Red/White/Blue Medicare Card:**

\_\_\_\_\_

\*\*\*\*\*Are you signing up for a new plan today? Y N

**Secondary Insurance**

Does the patient have secondary insurance? \_\_\_\_\_

Insurance Company \_\_\_\_\_

ID number \_\_\_\_\_

Company: \_\_\_\_\_

Effect. Date: \_\_\_\_\_

**PRESCRIBING PHYSICIAN INFORMATION**

**Name** \_\_\_\_\_ **Clinic** \_\_\_\_\_

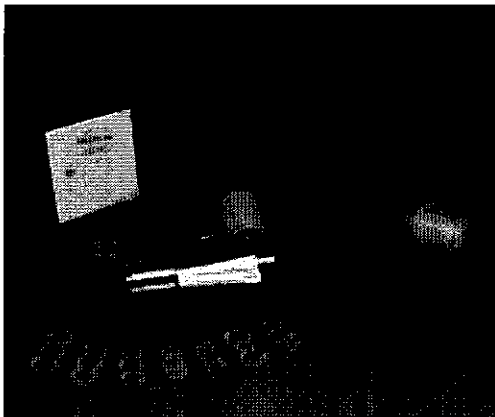
**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Fax** \_\_\_\_\_ **Date of Last Visit** \_\_\_\_\_

**NPI#** \_\_\_\_\_ **UPIN** \_\_\_\_\_

**MEDICAID #** \_\_\_\_\_

**[ ] ENCORE VACUUM THERAPY ERECTION SYSTEM**



***My signature authorizes each of the following:***

Assignment of Medicare, Medicaid or other insurance benefits to Lifeline and/or any of its affiliates for supplies furnished to me by Lifeline.

Direct Billing to Medicare, Medicaid or other insurers. I agree to pay for services provided to me or requested by me or on my behalf that are not paid by my insurance company or any other party responsible for payment of my supplies.

Release of my medical information to Medicare, Medicaid or any other insurer and their agents and assigns.

Lifeline and/or any of its affiliates to contact me by telephone or mail regarding my medical supplies and/or medications order.

I have received the Customer Service Rights Information, Return Policy, and the CMS Medicare Supplier Standards.

SIGN HERE

\_\_\_\_\_  
**CUSTOMER SIGNATURE** **DATE**

SIGN HERE

\_\_\_\_\_  
**AGENT SIGNATURE** **DATE**

## **VACUUM THERAPY SYSTEM**

WE HAVE A DEVICE COVERED BY MEDICARE FOR ERECTILE DYSFUNCTION. WOULD YOU LIKE MORE INFORMATION ON THIS ITEM? E.D. (or erectile dysfunction) IS THE DIFFICULTY OR INABILITY TO ACHIEVE OR MAINTAIN AN ERECTION.

THE VACUUM THERAPY SYSTEM IS A KIT WITH A BATTERY OPERATED VACUUM DEVICE AND A CYLINDRICAL TUBE. THE DEVICE IS 97% EFFECTIVE AT ALLOWING YOU TO HAVE AN ERECTION AND ENGAGE IN NORMAL SEXUAL ACTIVITY.

THE PENIS IS INSERTED INTO THE CYLINDRICAL TUBE AND YOU TURN ON THE VACUUM DEVICE. THIS WILL CAUSE A NEGATIVE PRESSURE OR VACUUM IN THE TUBE. THIS WILL INCREASE THE BLOOD FLOW TO THE PENIS, WHICH IN ESSENCE CREATES AN ERECTION.

IN ORDER TO MAINTAIN THE ERECTION THERE IS A SOFT RUBBER RING WHICH SITS AT THE BASE OF THE TUBE THAT YOU WILL EJECT TO THE BASE OF THE PENIS. THIS RING WILL HOLD THE ERECTION IN PLACE AND ALLOW FOR NORMAL SEXUAL ACTIVITY.

THIS DEVICE CAN ALSO BE USED AS A PHYSICAL THERAPY DEVICE. IF USED WITHOUT THE RUBBER RING DAILY FOR APPROXIMATELY ONE TO TWO MINUTES, THERE IS A 20-30% CHANCE THAT YOU WILL BE ABLE TO GAIN AN ERECTION AND RETURN TO NORMAL SEXUAL FUNCTION.

THIS DEVICE HAS NO SIDE EFFECTS. ORAL MEDICATIONS SUCH AS VIAGRA ARE ONLY 20-30% EFFECTIVE IN ELDERLY MEN. WITH THIS DEVICE THERE IS NO WAITING FOR THE ERECTION TO TAKE EFFECT LIKE WITH PILLS, AND THERE IS NO WAITING FOR THE ERECTION TO END.

DUE TO THE INTIMACY OF THIS DEVICE, WE WILL NOT ACCEPT IT BACK AS A RETURN. HAVE YOU RECEIVED THIS TYPE OF ITEM THRU MEDICARE IN THE PAST 5 YEARS?



# LIFELINE Diabetic

MOBILITY AIDS

## PHONE 866-558-8557

## FAX 888-918-2226

### PATIENT INFORMATION

**Patients Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Ship To Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Telephone** \_\_\_\_\_ **E-mail** \_\_\_\_\_ **Male** \_\_\_\_ **Female** \_\_\_\_

### INSURANCE INFORMATION

#### Primary Insurance

Medicare Claim Number \_\_\_\_\_

**Name as written on Red/White/Blue Medicare Card:**

\_\_\_\_\_

\*\*\*\*\*Are you signing up for a new plan today? **Y N**

#### Secondary Insurance

Does the patient have secondary insurance? \_\_\_\_\_

Insurance Company \_\_\_\_\_

ID number \_\_\_\_\_

Company: \_\_\_\_\_

Effect. Date: \_\_\_\_\_

### PRESCRIBING PHYSICIAN INFORMATION


**Name** \_\_\_\_\_ **Clinic** \_\_\_\_\_

**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Fax** \_\_\_\_\_ **Date of Last Visit** \_\_\_\_\_

**NPI#** \_\_\_\_\_ **UPIN** \_\_\_\_\_

### REQUESTED PRODUCTS:

PRODUCT	DESCRIPTION	ITEM#
VITAL WRAP SYSTEM	 <p>The Vital Wrap System is the first of its kind to provide both thermal and compression therapy in a single device, establishing what we believe to be the new standard of care for anyone treating or experiencing chronic pain or injury.</p>	E0217

**My signature authorizes each of the following:**  
 Assignment of Medicare, Medicaid or other insurance benefits to Lifeline and/or any of its affiliates for supplies furnished to me by Lifeline.  
 Direct Billing to Medicare, Medicaid or other insurers. I agree to pay for services provided to me or requested by me or on my behalf that are not paid by my insurance company or any other party responsible for payment of my supplies.  
 I authorize release of my medical information to Medicare, Medicaid or any other insurer and their agents and assigns.  
 I authorize Lifeline and/or any of its affiliates to contact me by telephone or mail regarding my medical supplies and/or medications order.  
 I have received the Customer Service Rights Information, Return Policy, and the CMS Medicare Supplier Standards.

SIGN HERE

AGENT SIGNATURE \_\_\_\_\_

SIGN HERE

CUSTOMER SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



**PATIENT INFORMATION**

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Ship To Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ E-mail \_\_\_\_\_ Male \_\_\_ Female \_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**

Medicare Claim Number \_\_\_\_\_  
Name as written on Red/White/Blue Medicare Card:  
\_\_\_\_\_

**Secondary Insurance**

Does the patient have secondary insurance? \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
ID number \_\_\_\_\_

\*\*\*\*\*Are you signing up for a new plan today? Y N

Company: \_\_\_\_\_  
Effect. Date: \_\_\_\_\_

**PRESCRIBING PHYSICIAN INFORMATION**

Name \_\_\_\_\_ Clinic \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
NPI# \_\_\_\_\_ UPIN \_\_\_\_\_  
MEDICAID # \_\_\_\_\_

**SUPPLIES INFORMATION**

Do you need a Monitor?  Yes  No If no what kind of monitor do you now have \_\_\_\_\_  
Supplies Requested  Strips  Lancets  Lancet Device  Control Solution  Batteries for Monitor  
Checks Blood Sugar \_\_\_\_\_ Times Daily (must check at least once a day)  
Are Insulin dependent?  Yes  No **Injects** \_\_\_\_ AM \_\_\_\_ PM  
Current Supplier \_\_\_\_\_ Date Last Received Supplies \_\_\_\_\_  
 Regular Heating Pad  Vitalwrap heating/cooling pad w/pump

SIGN HERE

SIGN HERE


WRITING AGENT

CUSTOMER SIGNATURE

**Diabetic Customer Agreement Form**  
203 3<sup>rd</sup> Ave South Amory, MS 38821 866-558-8557

Received By:

Please complete and return ASAP in order for us to process your diabetic supply request:  
My signature in the box below authorizes each of the following:  
• Assignment of Medicare, Medicaid or other insurance benefits to Lifeline Diabetic and/or any corporate affiliates for diabetic supplies furnished to me by Lifeline Diabetic.  
• Direct Billing to Medicare, Medicaid or other insurers. I agree to pay for any services provided to me or requested by me or on my behalf that are not paid by my insurance company or any other party responsible for payment of my supplies  
• Release of my medical information to Medicare, Medicaid; or any other insurer and their agents and assigns.  
• Lifeline and/or any of their corporate affiliates to contact me by telephone or mail regarding my medical supplies and/or medications order.  
• I have received the Customer Rights Information, Return policy, and the CMS Medicare Supplier Standards.

\_\_\_\_\_  
Your Phone Number Date  
Sign Your Name Here 


In order for us to bill Medicare and/or other insurance for your medical supplies, this form must be completed, signed, and dated as soon as possible.

**SIGN, DATE AND RETURN ENTIRE FORM QUICKLY**

**Diabetic Customer Agreement Form**  
203 3<sup>rd</sup> Ave South Amory, MS 38821 866-558-8557

Received By:

Please complete and return ASAP in order for us to process your diabetic supply request:  
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• Release of my medical information to Medicare, Medicaid; or any other insurer and their agents and assigns.  
• Lifeline and/or any of their corporate affiliates to contact me by telephone or mail regarding my medical supplies and/or medications order.  
• I have received the Customer Rights Information, Return policy, and the CMS Medicare Supplier Standards.

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Your Phone Number Date  
Sign Your Name Here 


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• Release of my medical information to Medicare, Medicaid; or any other insurer and their agents and assigns.  
• Lifeline and/or any of their corporate affiliates to contact me by telephone or mail regarding my medical supplies and/or medications order.  
• I have received the Customer Rights Information, Return policy, and the CMS Medicare Supplier Standards.

\_\_\_\_\_  
Your Phone Number Date  
Sign Your Name Here 

In order for us to bill Medicare and/or other insurance for your medical supplies, this form must be completed, signed, and dated as soon as possible.

**SIGN, DATE AND RETURN ENTIRE FORM QUICKLY**



**PATIENT'S APPLICATION FOR HARDSHIP WAIVER OF BALANCE DUE**

PATIENT'S NAME: \_\_\_\_\_

DATE OF APPLICATION: \_\_\_\_\_

BALANCE DUE: \_\_\_\_\_

*I am requesting that the balance due Lifeline Diabetic for medical supplies and/or durable medical equipment provided to the patient named above be waived because of hardship. To document the patient's need for this waiver, I am supplying the following information relating to the patient's financial resources and expenses.*

MONTHLY INCOME: \$ \_\_\_\_\_

MONTHLY EXPENSES FOR: \$ \_\_\_\_\_

Housing, including rent, utilities, insurance, taxes

MONTHLY EXPENSES FOR: \$ \_\_\_\_\_

Food, clothing, other necessities

MONTHLY MEDICAL EXPENSE \$ \_\_\_\_\_

OTHER EXPENSES \$ \_\_\_\_\_

If the figures shown above reflect that the patient's income exceeds the patient's normal monthly expenses, please explain very briefly below why a hardship waiver should be granted.

\_\_\_\_\_

\_\_\_\_\_

## QUESTIONNAIRE FOR ARTHRITIS PRODUCTS

1. Do you suffer from low back pain?
2. Do you have swelling of the wrist, elbow, knee, hands, feet?
3. Do you have tightness in your shoulders?
4. Do you have stiffness in your joints? Which?
5. Have you been diagnosed with arthritis?
6. Do you have tingling in your feet or hands at night?
7. Do you have trouble performing your regular daily activities due to pain and discomfort?
8. Do you have circulation problems?
9. Would you like to be able to move better and become more mobile?
10. If you have more than one arthritic problem area, name the three areas that effect you the most.
  - 1.
  - 2.
  - 3.



David A. Crotts  
& Associates Inc.  
Insurance



# DIAMETRICS

## COMMISSION ADDENDUM

### **MOBILITY PRODUCTS**

POWER WHEELCHAIRS	\$200
POSTURE -CORRECTING SHOULDER BRACE	\$30
COMFORT BACK BRACE (LSO)	\$30
VITAL WRAP SYSTEM	\$30
GEL MATTRESS OVERLAYS	\$30
DIABETICS	\$30
ERECTILE DYSFUNCTION	\$30
UPLIFT SEAT	\$30



# **LIFELINE** *Diabetic and Mobility*

## **ACCEPTABLE INSURANCES**

MEDICARE ONLY

MEDICARE + SUPPLEMENT

MEDICARE + MEDICAID

HUMANA GOLD CHOICE

TRICARE

CARE IMPROVEMENT PLUS

STERLING

FIRST HEALTH

HEALTHNET PEARL

UNICARE (PFFS)

INSTIL

ADVANTRA FREEDOM

PYRAMID

WELLCARE

AETNA

UNIVERSAL HEALTH

UNITED HEALTHCARE PLANS INCLUDING SECURE HORIZONS, EVERCARE, PACIFICARE

**\*\*MOST MEDICARE ADVANTAGE PLANS THAT ARE PFFS\*\***

WE CANNOT BILL MANY HMOs AND PPOs. AS WE ADD THEM TO OUR LIST, WE WILL UPDATE YOU.



# DIAMETRICS

## AGENT APPLICATION

### PERSONAL INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Email Address \_\_\_\_\_

### INSURANCE INFORMATION

Companies you represent \_\_\_\_\_

Resident State \_\_\_\_\_ Non-Resident Licenses \_\_\_\_\_

### COMPANY AFFILIATION

How did you hear about Diametrics? \_\_\_\_\_

Do you work with a brokerage or Insurance Company? Yes No \_\_\_\_\_

Do you have agents/employees in your downline? Yes No \_\_\_\_\_

I understand that by signing this contract I agree that I have read the CMS Medicare DME standards. I agree that I will abide by these standards when assisting an applicant in finding a supplier. I agree that I am not in any way affiliated with the Department of Insurance, CMS, Medicare, Medicaid, or any Government Entity. I agree that in order for me to assist a recipient in signing up for durable medical equipment products that they have signed a release and have read and understand their privacy rights and have read and understand the return policy. I also agree that I will supply them with any and all documentation provided by the Medicare Supplier Standards form. I agree that any application I submit, I will be charged back if the application is not able to be processed or does not remain on the books for a period of 6 months or longer. I agree that I will not submit DME related applications to any other company during my submission or for a period of two years after my relationship with Diametrics ends.

**SIGN HERE**

\_\_\_\_\_  
Agent Signature

\_\_\_\_\_  
Date

OFFICE USE ONLY	
AGENT ID: _____	PASSWORD: _____
DATE APPROVED: _____	SIGNATURE: _____

DIAMETRICS NON-COMPETE AGREEMENT

For good consideration and as an inducement for Diametrics to do business with \_\_\_\_\_, the undersigned Referral Company hereby agrees not to directly or indirectly compete with Diametrics and its successors and assigns during the period of the business contract and for a period of 2 years following the end of the business contract. Referral Company agrees that all referrals that are given to Diametrics are then the property of Diametrics and cannot be referred to another company during or after the business contract ends for a period of 2 years.

The term "non-compete" as used herein shall mean that the Referral Company shall not own, manage, operate, consult, enter into any business relationship similar to, or competitive with, the present business of Diametrics during the course of the business contract or for 2 years thereafter.

Diametrics acknowledges that they shall or may in reliance of this agreement provide the Referral Company access to trade secrets, customers and other confidential data and good will. The Referral Company agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party.

This non-compete agreement shall be in full force and effect for 2 years, commencing with the date of the end of the business contract. This agreement shall be binding upon and insure to the benefit of the parties, their successors, assigns, and personal representatives. Either party can end the business relationship within 10 days of supplying the other party with a written request to do so.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 2008.

\_\_\_\_\_  
Diametrics

\_\_\_\_\_  
Referral Company

## MARKETING AGENCY CONTRACT

This Agreement is made, effective as of the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by and between, **DIAMETRICS MEDIA GROUP**, a corporation organized and existing under the laws of the State of Mississippi, with its principal office located at \_\_\_\_\_, referred to in this Agreement as “Media Group,” and, \_\_\_\_\_, of \_\_\_\_\_, referred to in this Agreement as “Marketing Agency”

Both parties do hereby freely, voluntarily and willingly enter into this agreement as follows:

- 1. Generating leads.** Both parties agree and understand that all leads are to be generated through new or pre-existing insurance sales and/or customers, direct marketing by newspapers, television, radio, internet, direct mail or in person. Further, there shall be bulk mailings that should the customer decide to be contacted, they must sign or call in to the marketing center. Marketing Agency agrees and understands that per CMS guidelines, Marketing Agency will NOT participate in telephone solicitation (i.e. “cold-calling”) of Medicare recipients on the behalf of any DME supplier. Any cold calling will be grounds for immediate dismissal of contract.
- 2. Employment.** Marketing Agency agrees and understands that it is not an employee of Media Group for any purpose whatsoever, including unemployment tax, social security contributions, income tax withholding or workers compensation, whether state or federal. Further, Marketing Agency agrees and understands that it is not an employee of any DME company, Medicare or any other government entity. Any misrepresentation of this by Marketing Agency shall be grounds for the immediate suspension of referral submission to Diametrics Media Group.
- 3. Purpose of referrals.** Marketing Agency understands and agrees that any and all marketing referrals that are submitted by Marketing Agency unto Diametrics Media Group are for the purpose of providing referrals to DME related businesses. With that in mind, Marketing Agency understands and agrees that upon submission of referrals unto Diametrics Media Group, all Marketing Agency’s rights of information ownership pertaining to said referrals are thereby relinquished, that all of customer’s private health information (everything protected under HIPPA) on record with Marketing Agency shall be destroyed and disposed of.
- 4. Authentication of referrals.** Marketing Agency agrees and understands that by its submission of referrals to Diametrics Media Group, Marketing Agency authenticates and verifies

the validity of all the information submitted unto Diametrics Media Group. Should Diametrics Media Group discover fraudulent or inaccurate information, then Marketing Agency's ability to refer customers unto Diametrics Media Group shall be revoked and Diametrics Media Group may seek relief from any fraud or bad faith on the part of Marketing Agency as provided under the State laws of Mississippi. Further, Marketing Agency understands and agrees that should Marketing Agency fail to follow CMS guidelines as provided unto Marketing Agency that their right to refer to Diametrics Media Group will be revoked.

5. **Customer complaints.** Marketing Agency understands and agrees that should any customer complaint arise with DME company or Diametrics Media Group that Marketing Agent will be responsible for proving the validity of the referral either by providing copies of recorded conversations, copies of mail returned with customer's signature desiring contact, return receipts on any mailed items, etc.

6. **Payment.** Diametrics Media Group shall compensate Marketing Agency for any marketing provided by Marketing Agency to Diametrics Media Group. Once compensated, said marketing material becomes the exclusive property of Diametrics Media Group. Compensation for Marketing Agency referrals will be submitted once said referrals are verified by Diametrics Media Group.

7. **Maintenance of Customer Information.** In accordance with the HIPPA addendum attached to this agreement, Marketing Agency will NOT maintain any HIPPA protected Customer Information once said customer is referred to Diametrics Media Group. Once Diametrics Media Group purchases the referral, all Customer Information becomes property of Diametrics Media Group and Marketing Agency forfeits its rights to such information..

8. **Duration Of This Agreement.** This Agreement shall become effective on the date stated above, and shall remain indefinitely unless terminated for breach or as provided in this Agreement. This Agreement may be terminated by mutual agreement of Marketing Agency and Diametrics Media Group or by Diametrics Media Group's written notice of an intention to terminate the Agreement. Any such written notice shall serve automatically to terminate this Agreement thirty (30) days after the date such notice is sent to the other party via certified or registered mail.

9. **Assignment.** This Agreement is personal to the parties and may not be assigned by Diametrics Media Group or Marketing Agency without written consent by both parties

10. **Entire Agreement .** This Agreement shall constitute the entire Agreement (which includes addendums) between the parties and any prior understanding or representation of any kind preceding the date of this Agreement shall not be binding upon either party except to the extent incorporated in this Agreement.

11. **Modification of Agreement.** Any modification of this Agreement or additional obligation assumed by either party in connection with this Agreement shall be binding only if evidenced in writing signed by each party or an authorized representative of each party.

12. **Governing Law** It is agreed that this Agreement shall be governed by, construed, and enforced in accordance with the laws of the State of Mississippi.

13. **No Waiver**. The failure of either party to this Agreement to insist upon the performance of any of the terms and conditions of this Agreement, or the waiver of any breach of any of the terms and conditions of this Agreement, shall not be construed as thereafter waiving any such terms and conditions, but the same shall continue and remain in full force and effect as if no such forbearance or waiver had occurred.

14. **Effect Of Partial Invalidity** The invalidity of any portion of this Agreement will not and shall not be deemed to affect the validity of any other provision. In the event that any provision of this Agreement is held to be invalid, the parties agree that the remaining provisions shall be deemed to be in full force and effect as if they had been executed by both parties subsequent to the deletion of the invalid provision.

15. **Breach**. Both parties agree that in the event of material breach, the breaching party shall be responsible for all attorney's fees and court costs associated with the non-breaching party taking legal action.

16. **Notices** Any notice provided for or concerning this Agreement shall be in writing and shall be deemed sufficiently given when sent by certified or registered mail if sent to the respective address of each party as set forth at the beginning of this Agreement.

IN WITNESS WHEREOF, the parties have signed this Agreement as of the day and date first above mentioned.

\_\_\_\_\_  
Diametrics Media Group by representative



\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Print Name)  
(Print Title)

## Request for Taxpayer Identification Number and Certification

Give form to the  
 requester. Do not  
 send to the IRS.

Print or type See Specific Instructions on page 2.	Name	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ .....	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	
City, state, and ZIP code		
List account number(s) here (optional)		
Requester's name and address (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Social security number								
OR								
Employer identification number								

**Note:** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

**Sign Here**

Signature of U.S. person ▶



Date ▶

### Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

**Note:** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Foreign person.** If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515**, Withholding of Tax on Nonresident Aliens and Foreign Entities).

### Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.