



USANA Health Sciences (NZ) Corp.
PO Box 305001 Triton Plaza
North Shore City 0757
25 Canaveral Drive, Albany 0632
Auckland New Zealand
GST 069-107-461
0800-370-126 Order Line
0800-370-127 Fax Line
(61-2) 9842-4600 USANA Support Services
www.usana.com Online Ordering

AutoDeposit

Commission Direct Deposit Enrolment

The AutoDeposit program provides Associates with immediate availability of the weekly commission cheque on the cheque issue date.

No longer will Distributors need to wait for New Zealand Post to deliver the cheque.

AutoPay

Electronic Payment

The AutoPay program provides Associates and Preferred Customers a simple way to pay for your USANA Autoship orders. The funds for your purchase are electronically withdrawn from your enrolled bank account based upon the schedule provided by USANA.

To enrol in the Autodeposit or Autopay program, please complete two (2) original copies of the relevant form. Please do not send photocopies or faxed copies. USANA will only accept original Autopay and Autodeposit forms.

Original forms must be accompanied by proof of bank account details which clearly display your account number and branch number (for example copy of bank statement, deposit slip or cancelled cheque).

Enrolled Associates will continue to receive commission statements in the mail.

The Autodeposit and Autopay programs are available to all Associates that have bank accounts with the following banks:

- ANZ Banking Group (New Zealand) Ltd (incorporating Postbank)
- ASB Bank Ltd
- Bank of New Zealand
- Credit Union
- Kiwibank
- PSIS
- The Hongkong and Shanghai Banking Corporation Ltd
- The National Bank of New Zealand Ltd
- Trust Bank New Zealand Ltd
- TSB Bank
- Westpac Banking Corporation



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New Zealand Associate AutoDeposit Agreement

Name of Account holder

Customer to Complete Bank Account Number and Branch number
 Number & Suffix of Account to be credited

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Bank Branch

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Account Number

--	--	--

Suffix

To: The Manager, (Please Print Full Postal Address clearly for Window Envelope)

Name of Bank & Branch

Address (P.O. Box)

Town/City/ Post code

Post code

Date

I/We authorise you until further notice in writing to credit my/our account with you all amounts which USANA, the registered Initiator of the above Authorisation Code, may, initiate by Direct credit.

Please enrol me in the following programs subject to the terms and conditions below:

- AutoDeposit only** (please complete this form and attach proof of bank account details)
- AutoPay only** (please complete two (2) copies of the Autopay form and attach proof of bank account details)
- Autodeposit & AutoPay** (please complete two (2) copies of Autopay form & one (1) Autodeposit form along with proof of account details)

Terms and Conditions:

AutoPay: If so indicated above, I wish to participate in the AutoPay Program. I have read and agree to the following terms: I hereby authorise USANA Health Sciences (NZ) Corp to electronically withdraw payment from my bank account for my Autoship order. USANA Health Sciences (NZ) Corp is authorised to withdraw payment equal only to the amount of the product that I order, plus applicable GST and shipping or for the amount of the Autoship order I have established (plus additional amounts for substituted products if my regular products are unavailable. and G.S.T. and shipping. In the event an AutoPayment is dishonored for any reason I agree to pay a \$37.00 service fee. I shall indemnify and hold USANA Health Sciences (NZ) Corp harmless for any and all liability which may arise out of USANA Health Sciences (NZ) corp initiating an electronic payment on my account (except the liability to ship the product as ordered). I may stop this arrangement at any time, by so indicating to USANA Health Sciences (NZ) Corp in writing. The arrangement ends upon receipt of written notice. If this arrangement is stopped, I will pay for all orders in advance according to the then current policies. USANA Health Sciences reserves the right to cancel this agreement at any time.

AutoDeposit: If so indicated above, I wish to participate in the Autodeposit program. I have read and agree to the following terms: I hereby authorise USANA Health Sciences (NZ) Corp to electronically deposit my commission earnings into my bank account reduced by any normal fees or deduction as otherwise agreed. Furthermore, I authorise USANA Health Sciences to initiate, if necessary, direct entries and adjustments for any Autodeposit made in error. I may stop this arrangement at any time, by so indicating to USANA Health Sciences (NZ) Corp in writing. The arrangement ends seven days after receipt of written notice. USANA Health Sciences (NZ) Corp reserves the right to cancel this agreement at any time.

Associate ID#

Associate Signature

Date



HEALTH SCIENCES

New Zealand Autopay

(Direct Debit) Agreement

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The Autopay program enables Associates and Preferred Customers to pay for their Autoship order using the direct debit facility.
NB: Funds for Autoship purchases will be electronically withdrawn from your nominated bank on the Wednesday evening prior to your Autoship week.

Name of Account Holder

Associate/ Customer to Complete Bank Account Number and Branch Number
Number & Suffix of Account to Be Debited

Bank

Branch

Account Number

Suffix

To: The Manager, (Please Print Full Postal Address clearly for Window Envelope)

Name of Bank /Branch

Address (PO Box)

Town/City/ Post Code

AUTHORITY TO ACCEPT DIRECT DEBITS

(Not to operate as an assignment or agreement)

AUTHORISATION CODE

1 2 0 1 5 6 4

Date

I/We authorise you until further notice in writing to debit my/our account with you all amounts which

USANA Health Sciences (NZ) Corp
(hereinafter referred to as the Initiator)

the registered Initiator of the above Authorisation Code may initiate by Direct Debit.

I/We acknowledge and accept that the bank accepts this authority only upon the conditions listed on the reverse of this form.

INFORMATION TO APPEAR IN MY/OUR BANK STATEMENT

PAYER PARTICULARS (NAME)

PAYER CODE (ASSOCIATE/PC ID#)

PAYER REFERENCE (RO# - For office use only)

NAME OF ACCOUNT - CUSTOMER TO COMPLETE

AUTHORISED SIGNATURES

For Bank Use Only

Approved

0156

8/98

Date Received:

Recorded By:

Checked By:

BANK STAMP

