



MINA FOODS, INC.

ACCOUNT SETUP FORM

100 RESEARCH DRIVE MILFORD CT 06460

PHONE: (874) 874-6462 FAX: (203)874-8282

MINA SALES REP NAME

TRADE NAME/DBA CORPORATE E

SHIP TO ADDRESS CONTACT

CITY STATE ZIP PHONE# FAX#

STATE TAX REGISTRATION # LIQUOR LICENCE #

A/P NAME EMAIL ADDRESS

COMPANY TYPE ☐ INDIVIDUAL ☐ PARTNERSHIP DATE OF INCORPORATION

☐ LLC ☐ CORPORATION STATE INCORPORATED

LOCATION TYPE: ☐ RENT ☐ LEASE NAME OF BANKING INSTITUTION

☐ OWN ACCOUNT # BANK CONTACT NAME

DELIVERY HOURS:

NAME OWNER/S DRIVER'S LICENCE # SOCIAL SECURITY #

HOME ADDRESS CITY STATE ZIP

HOME PHONE # CELL #

TRADE REFERENCES:

NAME TERMS PHONE #

NAME TERMS PHONE #

NAME TERMS PHONE #

TERMS:

Applicant's signature attests to financial responsibility, ability, and willingness to pay our invoices in accordance with the following terms:

1. I/We authorize all banking and trade references to release information to Mina Foods, Inc. for its confidential use.
2. I/We agree to notify Mina Foods, Inc. immediately of any change of ownership.
3. All product returns must be authorized and all shorts must be notified within twenty four (24) hours of delivery.
4. All returned checks are subject to a service charge.
5. Standard credit terms are seven (7) days from date of purchase.
6. All invoices will be paid according to our stated terms, otherwise they will be considered delinquent and may be placed for collection.
7. IF THE ACCOUNT BECOMES DELINQUENT, I ACKNOWLEDGE AND AGREE TO PAY ALL COLLECTION COSTS, ATTORNEY'S FEES, COURT FEES AND INTEREST OF 1.5% MONTHLY

In consideration of Mina Foods, Inc. (Seller) selling goods, wares, and merchandise upon credit or allowing additional time for payment on the present indebtedness, I hereby personally guarantee payment of any and all obligations incurred and agree to personally pay the said obligations, in accordance with the terms between the parties, in the event of default.

Owners' Names (Please Print)

Owners' Signatures

Date

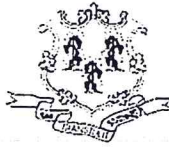
Owners' Names (Please Print)

Owners' Signatures

Date

Officer/Member's Name (Please Print)

Officer/Member



STATE OF CONNECTICUT
DEPARTMENT OF REVENUE SERVICES

SALES & USE TAX RESALE CERTIFICATE

Issued to (Seller)

Address

MINA FOODS, INC.

BLANKET CERTIFICATE

100 RESEARCH DRIVE MILFORD, CT 06460

I certify that Name of Firm (Buyer)

is engaged as a registered

Street Address or P.O. Box No.

City

State

Zip

- () Wholesaler
() Retailer
() Manufacturer
() Lessor
() Other (specify)

and is registered with the below listed states and cities within which your firm would deliver purchases to us and that any such purchases are for wholesale, resale, ingredients or components of a new product to be resold, leased, or rented in the normal course of our business. We are in the business of wholesaling, retailing, manufacturing, leasing (renting) the following:

City or state

State Registration
or I.D. No.

City or State

State Registration
or I.D. No.

City or state

State Registration
or I.D. No.

City or State

State Registration
or I.D. No.

City or state

State Registration
or I.D. No.

City or State

State Registration
or I.D. No.

I further certify that if any property so purchased tax free is used or consumed by the firm as to make it subject to a sales or use tax we will pay the tax due direct to the proper taxing authority when state law so provides or inform the seller for added tax billing. This certificate shall be part of each order which we may hereafter give to you, unless otherwise specified, and shall be valid until cancelled by us in writing or revoked by the city or state.

General description of products to be purchased from the seller:

I declare under the penalties of false statement that this certificate has been examined by me and to the best of my knowledge and belief is a true, correct and complete certificate.

Authorized Signature

(Owner, Partner or Corporate Officer)

Title

Date



100 Research Drive Milford, CT. 06460
Tel: 203-874-6462 Fax: 203-874-8282

DELIVERY INSTRUCTIONS

NAME OF BUSINESS

OWNER'S NAME

TELEPHONE OR CELLPHONE

MANAGER'S NAME

SHIP TO ADDRESS

CITY

STATE

ZIP

NUMBER OF DELIVERIES PER WEEK _____

TIME OPEN FOR DELIVERIES: EARLIEST (AM) _____ LATEST (PM) _____

CHECK APPLICABLE DELIVERY LOCATION:

STAIRS: UP () DOWN () HOW MANY STAIRS: _____

() DOCK DELIVERY () STREET DELIVERY () FRONT DOOR DELIVERY
() PALLET DELIVERY () SIDE DOOR DELIVERY () REAR DOOR DELIVERY

SPECIAL DELIVERY INSTRUCTIONS:

