



CO-OP ADVERTISING AGREEMENT

ATTN: Marketing Representative

Fax To: (410) 581-8070

Contact Name _____ Customer # _____

Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

I/We _____ agree to comply with the terms and conditions set forth within the Medifast Co-op Advertising Policy and Procedures. I/We understand that failure to comply will void this contract and thus result in ineligibility for any reimbursement. Medifast will provide reimbursement for most traditional methods of promotion, which includes print, radio, and television advertisements. Reimbursement for non-traditional methods of promotion should be discussed with the Medifast Marketing Department prior to the launch of your campaign. Medifast reserves the right to deny any inappropriate or questionable form of promotion or advertising.

SIGNATURE

DATE

PRINTED NAME

SIGNATURE

DATE

PRINTED NAME

Please Note: Each advertisement you submit for Co-op Advertising Reimbursement must be approved by the Medifast Marketing Department prior to being placed/run in the media chosen. Acceptance into the Medifast Co-op Advertising Program does not guarantee approval of all advertising initiatives.

For Office Use Only:

Date Received

Approved by