Welcome to sanofi-aventis U.S. LLC and Genzyme Corporation. This new account welcome kit provides you with essential information on how to request a new account and understand our standard business policies and procedures. Listed below are the action steps you need to take in order to apply for a new account.

Documents needed to open an account:

- **sanofi-aventis U.S. LLC/Genzyme Corporation New Customer Application**
  This application starts the process of opening a new customer account with us. Our Terms and Conditions document is attached. Please review the Terms and Conditions and contact us if you have any questions.
- State License
- DEA Certificate or HIN Number
- Tax Exemption Certificate [if applicable]

Customer partner set up in our system:

Each customer is set up with a Sold To, Ship To, Bill To and Payer partner account (see definitions below). Please provide a Name and Address for the respective partner accounts on Page 2 of the New Customer Application. The Supplemental Address Form on Page 5 should be used for additional Ship To addresses as needed.

- ***Ship To: The address of the business partner/facility where we ship the product.***
- ***Sold To: The address of the business partner/facility which places an order for the product (typically the same as the Ship To name and address).***
- ***Bill To: The address where we will send invoices for the product shipped.***
- ***Payer: The address of the business partner/facility that pays for the invoice (the "Applicant").***

Your next step:

Please complete the New Customer Application and send it, along with the other documents mentioned above, to us via fax (908-243-9201) or email: SAPDataIntegrity@sanofi.com.

Our next step:

Once your account is established, you will receive a confirmation email or fax with your account number and an order form.

Thank you for choosing sanofi-aventis U.S. LLC and Genzyme Corporation. If you have any questions about the steps necessary to apply for a new customer account, please contact your sales representative or simply call 1-800-372-6634 to speak with a customer support representative.

SANOFI

genzyme
A SANOFI COMPANY

New Customer Application

Please email completed form and licenses to: SAPDataIntegrity@sanofi.com or fax to: 908-243-9201

Ship To Information

The address of the business partner/facility where we ship the product

Facility Name _____

Physician Name, if applicable _____

Address _____

Suite _____

City _____

State _____

Zip _____

Purchasing Contact _____

Phone _____

Fax _____

Purchasing Email _____

DEA # or HIN # _____

DEA Expiration Date_____

Bill To Information

The address where we send invoices for the product shipped

Facility Name _____

Physician Name, if applicable _____

Address _____

Suite _____

City _____

State _____

Zip _____

Billing/AP Contact _____

Phone _____

Fax _____

AP Email _____

Email for Invoice (if different) _____

Tax ID # _____

Sold To Information

The address of the business partner/facility which places orders for product

State License #, **copy required** _____

Check below if Sold To Name/Address is the same as

☐ *Ship To*

If different please complete below

Facility Name _____

Physician Name, if applicable _____

Address _____

Suite _____

City _____

State _____

Zip _____

Payer Information

The address of the business partner/facility that pays the invoice

D&B # _____

Check below if Payer Name/Address is the same as

☐ *Ship To* *or* ☐ *Bill To*

If different please complete below

Facility Name _____

Physician Name, if applicable _____

Address _____

Suite _____

City _____

State _____

Zip _____

Account Information

Type of Facility		Legal Status
☐ Clinic	☐ 340B Entity; 340B #	☐ Public Corporation
☐ Hospital	☐ Department of Defense	☐ Private Corporation
☐ Physician	☐ Veteran Facility (VA)	☐ Partnership
☐ Long Term Care	☐ Independent Retail	☐ Limited Liability Corporation
☐ Specialty Pharmacy	☐ Chain Retail	☐ Sole Proprietor
☐ Other (Please describe below)	☐ Mail Order Pharmacy	☐ Other (Please describe below)

Anticipated Monthly Purchase Volume	☐ $25,000	☐ $50, 000	☐ $100,000	☐ Over $100,000
What Products Are You Interested in Purchasing?				

If your business has an account with another Sanofi or Genzyme division, please provide the following:

Division Name:	Your Account Number:
Division Name:	Your Account Number:

Bank Information

Bank Name	Your Account Number	Bank Contact Name	Phone or Email

Credit Reference Information (please provide 3 vendor references)

Company Name	Your Account Number	Company Contact Name	Phone or Email

General Business Information

Are you willing to share additional financial information with us on a confidential basis?		☐ No	☐ Yes	
Are there any prior bankruptcies of principal owners and/or businesses?	☐ No	☐ Yes	*If yes, please attach detailed explanation*	
Are there any pending lawsuits against the business?	☐ No	☐ Yes	*If yes, please attach detailed explanation*	
How would you like to receive invoices?	☐ EDI	☐ Email	☐ Fax	☐ Paper
How will you be paying for shipments?	☐ EFT	☐ Check	☐ Credit Card	
If you are part of a healthcare system, please indicate the name:				

Terms and Conditions Agreement

Your signature below indicates you are an owner, officer, or authorized buyer of Applicant and Applicant fully accepts the Terms and Conditions of becoming a direct purchasing customer of sanofi-aventis U.S. LLC and/or Genzyme Corporation products. A copy of our Terms and Conditions document is attached.

Form of Verification of Accuracy of Information and Authorizing Credit Check

The undersigned, on behalf of and authorized by the Applicant, hereby certifies the foregoing information, including references and all other documents submitted herewith, are true and accurate in every respect. The foregoing information is being provided in order to allow sanofi-aventis U.S. LLC and/or Genzyme Corporation (The Company) to determine if the Applicant will be granted credit, and will be relied on by The Company in making its credit decision. The undersigned further agrees to notify The Company forthwith upon receipt of information that any of the foregoing is not completely accurate. The undersigned further authorizes The Company to gather and use, from time to time, without the undersigned's knowledge, any and all financial and/or credit information relating to the Applicant that can be obtained from any source whatsoever. In connection therewith, the undersigned hereby authorizes any and all Bank and Trade references listed above to release to The Company such information as The Company may request in connection with its investigation of the credit worthiness of the Applicant.

_____ Print Name

_____ Title

_____ Authorized Signature

_____ Date

For Internal Use	___ IS Team	___ OS Team

New Customer Application Supplemental Address Form *

* Use this form for additional ship to locations

Ship To Information

The address of the business partner/facility where we ship the product

Facility Name _____

Physician Name, if applicable _____

Address _____

Suite _____

City _____

State _____

Zip _____

Purchasing Contact _____

Phone _____

Fax _____

Purchasing Email _____

DEA # or HIN # _____

DEA Expiration Date _____

Ship To Information

The address of the business partner/facility where we ship the product

Facility Name _____

Physician Name, if applicable _____

Address _____

Suite _____

City _____

State _____

Zip _____

Purchasing Contact _____

Phone _____

Fax _____

Purchasing Email _____

DEA # or HIN # _____

DEA Expiration Date _____

Note: If an account has more than one ship to location, please submit a copy of the respective DEA certificate (if applicable) or HIN # for all additional locations. Each active ship to location must have a unique DEA # or HIN # that matches the ship to name and address.

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