AGEL PREFERRED CUSTOMER

NAME	
BILLING ADDRESS ***(FOR CREDIT CARD)***	
STREET _	
CITY	**STATE** **ZIP**
SHIP TO ADDRESS ***(IF DIFFERENT)***	
STREET _	
CITY	**STATE** **ZIP**
PHONE	**CELL PHONE**
E-MAIL	
CREDIT CARD #	☐ **VISA** ☐ **MC** ☐ **AE** ☐ **DISCOVER**
EXP DATE	**CID** ***(SECURITY CODE)***

PRODUCT / QUANTITY

AGELESS Full Size Kit ________ Trial Size Kit ________

Age Defying Eye Gel ________

Daily Moisturizing Gel ________

Gentle Daily Cleansing Gel ________

Intensive Anti-aging Gel Serum ________

Nourishing Night Gel ________

Refreshing Anti-oxidant Misting Gel ________

CAL ________

EXO ________

FIT ________

FLX ________

GLO ________

HRT ________

MIN ________

OHM ________

PRO Chocolate Truffle ________ Strawberry/Banana ________

UMI ________

SIGNATURE: