

Grow Bone Challenge Reimbursement Request Form

To be reimbursed for your full body DEXA scans and double the cost of the Grow Bone System kits that you purchased, follow the directions below. **Requests must be postmarked no later than 60 days of your second full body DEXA scan.**

Please complete this original reimbursement form and mail it with:

- a) The original or copy of the store-identified cash register receipt(s) for each of your Grow Bone System purchases with the purchase price circled, and
- b) The six (6) original UPC symbols off your Grow Bone System cartons
- c) Copies of the reports from both of your full body DEXA scans taken at least 6 months but no more than 8 months apart.
- d) Send to: **The Grow Bone Challenge** c/o Garden of Life, Inc. 5500 Village Boulevard, West Palm Beach, FL 33407.

I agree to the terms and conditions of **The Grow Bone Challenge** incorporated herein by reference and certify that I do not take, nor have I taken in the preceding twelve months: any medications that are exceptions (promote bone loss), nor am I in early post-menopause. After a full body DEXA scan I took **Vitamin Code Grow Bone System** which includes **Vitamin Code RAW Calcium** and **Vitamin Code Growth Factor S** as directed for a minimum of 180 consecutive days followed by another full body DEXA scan then took another full body DEXA scan which when compared to the first showed absolutely no improvement in my bone density.

Opt in: By providing this information, you acknowledge that Garden of Life may also send you information, samples or special offers it feels may be of interest to you about Garden of Life products. If you would like more information about Garden of Life's privacy policy, please visit www.gardenoflife.com or call 866-465-0051.

HIPAA Disclosure: I have chosen to release the information submitted with this form to Garden of Life for the purpose of fulfilling the reimbursement that I have requested. I understand that Garden of Life may use the information internally and/or may further disclose this information in connection with this reimbursement request. I further allow Garden of Life and/or their appointed agent to contact the imaging facility that performed my DEXA scans in order to confirm the validity of the scans and the results and/or the veracity of any information that I have given within this form. I may choose to revoke this authorization at anytime in writing (by certified mail) but it will automatically expire 18 months from submission of this form.

Please print legibly:

Imaging Facility: _____ Phone: _____

Date of 1st Scan: ____/____/____ Date of 2nd Scan: ____/____/____

Signature: _____ Date: _____

Please print legibly:

Name: _____

Address: _____ APT/SUITE: _____

City: _____ State: _____ Zip: _____

Email: _____ @ _____

SPONSOR: Garden of Life, Inc. 5500 Village Boulevard, West Palm Beach, FL 33407 (866)-465-0051