



SUBSCRIPTION ORDER FORM

Company Name			
P.O. Box			
City		Emirate	
Contact Person			
Designation			
Telephone No:		Extn:	
Fax No:			
Mobile No:			

Delivery Location

Area:			
Building Name:		Suite:	
Road/Street			
Landmarks			

Subscription Details

Type	Placement	Qty	Frequency	Rate
Start Date			Contract Value	
End Date			Billing Cycle	30 days

Delivery Day	<input type="checkbox"/> Sat <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu	Time:	
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I/We agree to the terms of the service as printed overleaf and confirm our subscription.

Customer's Signature / Seal	Date: Sales Executive
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FAX BACK TO 04 340 1955