CHEMAT VISION Partner for ECPs Optical Labs

ACCOUNT APPLICATION

Please complete this application and fax to the following:

CHEMAT VISION CREDIT DEPARTMENT 818-727-9477

CHEMAT USE ONLY

CUSTOMER ACCOUNT NUMBER (CAN#)

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NEW ACCOUNT INFORMATION

BUSINESS NAME: _____

OWNER'S NAME: _____

BUSINESS LICENSE NUMBER (Resale #): _____

BUSINESS ADDRESS: _____

CITY _____ STATE _____ ZIP _____

PHONE: _____ FAX: _____

CONTACT NAME: _____

EMAIL ADDRESS: _____

YEARS IN BUSINESS: _____ YEARS AT PRESENT LOCATION: _____

HOW MUCH MONTHLY CREDIT ARE YOU APPLYING FOR? _____

BANK REFERENCE

NAME OF BANK: _____

NAME: _____ CHECKING ACCT #: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PHONE: _____ BANK CONTACT: _____

TERMS AND CONDITIONS

1. If you would like us to automatically charge your monthly invoices to your credit card, please enter your credit card information below.
   Credit Card Number: _____ **Expiration Date**: _____
   Billing Address: (if different from above)_____
   Name on Credit Card: _____
2. Terms are net, 30 days E.O.M.
3. A service charge of 1.5% (18% APR) will be applied to all balances unpaid after thirty (30) days E.O.M.
4. CHEMAT VISION reserves the right to amend the terms and conditions of this agreement anytime by written notice.
5. CHEMAT VISION reserves the right to decline its service to anyone at anytime.

I, the undersigned, hereby agree that in the event of default in the payment of any amount due on this account, I will be personally liable for the unpaid balance. Also, in the event this account is placed in the hands of an agency or attoney for collection, I am responsible to pay all the charges equal to the cost of collection including agency and attoney fees and the court costs incurred and permitted by laws governing these transactions.

I also certify that all the information and statements in this application are true and complete and are made for the purpose of obtaining credit. I give CHEMAT VISION the right to contact any reference listed.

Name of the Financially Responsible Officer_____ Title: _____

Signature of the Officer: _____ Date_____

BUSINESS REFERENCES (a minimum of three are required)

1. NAME: _____ ACCOUNT #: _____

   ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

   PHONE: _____ CONTACT: _____

2. NAME: _____ ACCOUNT #: _____

   ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

   PHONE: _____ CONTACT: _____

3. NAME: _____ ACCOUNT #: _____

   ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

   PHONE: _____ CONTACT: _____

CHEMAT SALES REP USE ONLY

SALES REP NAME: _____

SALES REP ID#: _____

SALES REP'S COMMENTS: _____

_____

_____

BUSINESS DETAILS

TYPE OF BUSINESS: □ RETAIL FINISHING LAB □ RETAIL SURFACING LAB □ OTHER _____

TYPE OF ECPS: □ OPTHOMOLOGIST □ OPTOMETRIST □ OPTICIAN NUMBER OF ECPS: _____

NUMBER OF LOCATIONS _____ (attached a separate page for the details of these locations)

NUMBER OF JOBS _____ PER DAY _____ PER MONTH

ESTIMATED MONTHLY SALES VOLUME: $_____

DIVISION CODE ☐☐☐☐ PRICE COLUME: □ VI □ VII □ VIII

SHIPPING METHOD: _____ FREIGHT BILLING: □ YES □ NO

CHEMAT CREDIT DEPARTMENT USE ONLY

CREDIT STATUS: _____ CREDIT LIMIT: _____

NOTES: _____

_____

_____

Name of Credit Officer _____ Date _____

Signature of Credit Officer _____