

GK Optical INC Credit Application

1000 Paradise Court, Greenwood, IN 46143

PLEASE FAX CREDIT APP TO: (800) 566.6950

OWNER INFORMATION

Owner Name: _____ S.S. # _____

Address: _____

BUSINESS CONTACT INFORMATION

Company name: _____

Phone: _____ Fax: _____ E-mail: _____

Registered company address: _____

City: _____ State: _____ ZIP Code: _____

Date business commenced: _____

MD Practice: _____ OD Practice: _____ Optical only: _____ Other: _____

BUSINESS AND CREDIT INFORMATION

Primary business address: _____

City: _____ State: _____ ZIP Code: _____

How long at current address? _____

Telephone: _____ Fax: _____ E-mail: _____

Bank name: _____

Bank address: _____ Phone: _____

City: _____ ZIP Code: _____

Type of account _____ Account #: _____

Savings _____

Federal ID #: _____

Type of business: _____

BUSINESS/TRADE REFERENCES

Company Name: _____
Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ E-mail: _____

Type of account: _____

Company name: _____
Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ E-mail: _____

Type of account: _____

Company name: _____
Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ E-mail: _____

Type of account: _____

AGREEMENT

1. All invoices are to be paid 30 days from the date of the invoice.
2. Claims arising from invoices must be made within seven working days.
3. By submitting this application, you authorize GK Optical to make inquiries into the banking and business/trade references that you have supplied.

SIGNATURES

Title: _____
Date: _____ Personal Guarantee: _____