Customer Account Application Form

PLEASE RETURN BY FAX **416-739-8144** OR BY E-MAIL: *accounting@centennialoptical.com*

GENERAL

FULL LEGAL CORPORATE/PERSONAL NAME(s) | YEARS IN BUSINESS

COMPANY'S TRADE NAME(s)

☐ *same as above*

Have you done business with Centennial under ***another account*** in the past? ☐ YES ☐ NO

PREVIOUS ACCOUNT NAME | PREVIOUS ADDRESS

Ownership: ☐ PROPRIETORSHIP ☐ CORPORATION ☐ PARTNERSHIP ☐ SUBSIDIARY

☐ OPTOMETRIST ☐ WHOLESALE LAB ☐ OPTICIAN ☐ RETAIL LAB ☐ OPHTHALMOLOGIST ☐ OTHER _____ Specify

Principal Directors/Officers/Shareholders of Corporation "Guarantor"

NAME	TITLE	PHONE
NAME	TITLE	PHONE

BILL-TO INFORMATION

NAME

ADDRESS

CITY | PROVINCE | POSTAL CODE

PHONE | FAX | E-MAIL ADDRESS

SHIP-TO INFORMATION

☐ *same as above*

NAME | PST #

Attach a copy of certificate

ADDRESS

CITY | PROVINCE | POSTAL CODE

PHONE | FAX | E-MAIL ADDRESS

PAYMENT OPTION: ☐ CHEQUE ☐ MASTERCARD ☐ VISA

BANK REFERENCES

BANK NAME | PHONE

ADDRESS

ACCOUNT # | CONTACT

TRADE REFERENCES

NAME	ADDRESS
NAME	ADDRESS
NAME	ADDRESS

TERM AND CONDITIONS: The undersigned acknowledges that all purchases are due and payable within the normal terms of Centennial Optical Limited which give Centennial the right to perform credit checks on the above applicant.

Normal payment terms are: *NET 10th DAY OF FOLLOWING MONTH*, unless different terms have been established.

A 2% MONTHLY SERVICE CHARGE will apply to all accounts over 60 days past due.

The undersigned official hereby guarantees the company's payment of any and all purchases from Centennial Optical Limited.

PRINCIPAL'S NAME (please print)	SIGNATURE	DATE