

APPLICATION FOR CREDIT

Emergency or rush?
Please check here.



APPLICANT'S INFORMATION

Mr. <input type="checkbox"/>	Mrs. <input type="checkbox"/>	First Name & Initial(s):			Last Name:		Date of Birth: (DD/MM/YY)
Ms. <input type="checkbox"/>	Miss <input type="checkbox"/>						
Home Number:		Work Number:		Cell Number:		Email:	
Present Address:		Apt #:	City:	Prov.:	Postal Code:		How Long At This Address?
Own <input type="checkbox"/>	Rent <input type="checkbox"/>	Parents <input type="checkbox"/>	Monthly Rent or Mortgage: \$	Mortgage Lender:	Social Insurance # (Optional):		Driver's License # + Province (Optional in Québec):
Occupation:		Present Employer (Company Name):		Contact Name:		Employer's Phone Number:	Length of Employment:
Full Time <input type="checkbox"/>	Part Time <input type="checkbox"/>	Retired <input type="checkbox"/>	Self Employed <input type="checkbox"/>	Student <input type="checkbox"/>	Gross Monthly Income: \$		Other Income (Specify): \$
If Self Employed, State Name of Source of Income / Accountant:						Accountant's Phone Number:	
Please provide two personal references		#1 First Name:		Last Name:		Phone Number:	
		#2 First Name:		Last Name:		Phone Number:	

CO-APPLICANT'S INFORMATION (If any)

Mr. <input type="checkbox"/>	Mrs. <input type="checkbox"/>	First Name & Initial(s):			Last Name:		Date of Birth: (DD/MM/YY)
Ms. <input type="checkbox"/>	Miss <input type="checkbox"/>						
Home Number:		Work Number:		Cell Number:		Email:	
Present Address:		Apt #:	City:	Prov.:	Postal Code:		How Long At This Address?
Own <input type="checkbox"/>	Rent <input type="checkbox"/>	Parents <input type="checkbox"/>	Monthly Rent or Mortgage: \$	Mortgage Lender:	Social Insurance # (Optional):		Driver's License # + Province (Optional in Québec):
Occupation:		Present Employer (Company Name):		Contact Name:		Employer's Phone Number:	Length of Employment:
Full Time <input type="checkbox"/>	Part Time <input type="checkbox"/>	Retired <input type="checkbox"/>	Self Employed <input type="checkbox"/>	Student <input type="checkbox"/>	Gross Monthly Income: \$		Other Income (Specify): \$
If Self Employed, State Name of Source of Income / Accountant:						Accountant's Phone Number:	
Please provide two personal references		#1 First Name:		Last Name:		Phone Number:	
		#2 First Name:		Last Name:		Phone Number:	

I/we are interested in the Optional Creditors Life & Accidental Disability Insurance Program. I/we understand that it is not required in order to obtain credit. The Creditor's Life Insurance Program protects my/our account for the balance of the loan, to be paid in full, if the borrower(s) should die. The Accidental Disability Program protects my/our account for the monthly payment if the borrower(s) should become totally disabled due to injury. The cost of the insurance will be added to my fixed monthly payments at a cost of \$1.50 per \$100.00 per year for single and \$2.70 per \$100.00 per year for joint insurance. For further information, contact iFinance. Underwritten by subsidiaries of First Creditors Insurance Ltd. *Applicable to the fixed monthly payments program only. ** Insurance may not be offered in all provinces.

If you are a business owner and interested in deducting 100% of your medical expenses, check here for more information.

TERMS AND CONDITIONS

I/we understand that the above information (the "Collected Information") is being collected for the purpose of obtaining credit from Medicard, a division of iFinance Canada Inc. ("iFinance") and is warranted to be true and complete. I/we hereby authorize and consent to the collection of the Collected Information and to the making by iFinance, its successors and assigns of whatever credit investigations and/or employment and income confirmations iFinance or its successors and assigns may deem appropriate from time to time, and to the disclosure, sharing or exchange of the Collected Information and any report or information based thereon for these purposes with credit reporting agencies, and amongst iFinance, its successors and assigns or any company with whom I/we have or propose to have a financial relationship.

READ ADDITIONAL TERMS AND CONDITIONS BELOW AND SIGN WHERE INDICATED IF YOU ACCEPT THESE TERMS.

If approved, iFinance will contact your provider or medical facility.

X _____ Date _____
Signature of Applicant

X _____ Date _____
Signature of Co-Applicant (if applicable)

Patient's Name (If applicable) Approximate Date of Procedure

\$ _____
Amount of Financing Required Medical Treatment Centre / Doctor's Name

Please check one:

- Fixed monthly payment
 6 mths 1 yr 2 yrs 3 yrs 4 yrs 5 yrs 6 yrs
 or
 Credit card (i.e. for amounts under \$200. See terms below)