APPLICATION FOR CREDIT

Emergency or rush?
Please check here.





Mis Mis Mis First name Work priors number: Gold phone number: Email: Provided sode Provided	APPLICANT'S IN	NFORMA	TION						Date of hirth: (DDAMANO)	
Frescrit solutions: Process Service Process Proce		First name	e & initial(s):			Last name:			Date of birth: (DD/MM/YY)	
Morting of the control of the cont	Home phone number:		Work pho	ne number:		Cell phone number:		Email:		
Personal configuration Personal configurat	Present address: Apt#: City:				Prov:			_	-	
Present dumployer:	Own Rent F	Parents		rtgage: Mortgage I	ender:	Social Insurance Number: (Optional) Driver's license N			nd province: (Optional in Québec)	
Full time Part time Part time Rested Self employed Suddent Sud	Occupation:	7			Contact name:	Employer's p		s phone number:	Length of employment:	
Ploase provide 2 personal references #Z First name: Last name: Phone number: Part name: Phone number: Part name: Phone number: Part name: Phone number: Part name: Phone number: Phone num	Full time Part time	e 🗌 Retire	red Student		income:		Other income: (Specify) \$	her income: (Specify)		
Please provide 2 personal references Present address: Prest name: Phone number: Date of birth: coawery	If self employed, state name of source of income / accountant:					Ac			countant's phone number:	
Last name: Phone number: Date of birth: governey Procedure		me:	Las			9	Phone number:	Phone number:		
Date of birth: purvaewany		#2 First na	me:		Last name:			Phone number:	Phone number:	
Home phone number: Work phone number: Cell phone number: Cell phone number: Email:	CO-APPLICANT	r's INFO	RMATION (If a	iny)						
Present address: Apt#: City: Prov: Postal code: How long at this address?:		First nam	ne & initial(s):			Last name:			Date of birth: (DD/MM/YY)	
Own Parents Parents Monthly rent or mortgage: Mortgage lender: Social Insurance Number: (optional) Driver's license No. and province: (optional of Outbook)						Cell phone number:		Email:	***	
Occupation: Present employer: (concent preme) Contact name: Employer's phone number: Length of employment:	Present address:		City:	Prov:	Postal code:		How long at this addr	How long at this address?:		
Contact name: Employer's phone number: Length of employment:	Own Rent Parents				lender:	Social Insurance Num	ber: (Optional)	Driver's license No. a	Driver's license No. and province: (Optional in Québec)	
If self employed, state name of source of income / accountant: Accountant's phone number:	Occupation:	F	1 1	ompany name)	Contact name	:	Employer	's phone number:	Length of employment:	
If self employed, state name of source of income / accountant: Accountant's phone number:	Full time Part tim	e 🗌 Retir	ed Self emplo	yed Student		/ income:				
Please provide 2 personal references #2 First name: Last name: Phone number: Last name: Phone number: Phone number:	If self employed, state	name of sou	rce of income / acco	untant:	1 *	ų T			ccountant's phone number:	
Last name: Phone number:		#1 First name:			Last name:	Last name:			Phone number:	
account for the balance of the loan, to be paid in full, if the borrower(s) should die. The Accidental Disability Program protects mylour account for the monthly payments in the borrower(s) should deed 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 insights and \$2.70 per \$100.00 per year for 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, if if insights and insight		#2 First na	ame:		Last name:			Phone number:	Phone number:	
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. 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 Signature of Applicant Date Approximate date of procedure Fixed Monthly Payments Please check one:	account for the balance of due to injury. The cost of the iFinance. Underwritten by	f the loan, to be he insurance w / subsidiaries o	paid in full, if the borrow ill be added to my fixed of First Creditors Insurar	ver(s) should die. The Acc monthly payments at a conce Ltd. *Applicable to the	cidental Disability Pr ost of \$1.50 per \$10 e fixed monthly pay	ogram protects my/our accor 0.00 per year for single and \$ ments program only. ** Insur	unt for the mo \$2.70 per \$10 ance may no	onthly payment if the borrower(: 10.00 per year for joint insuranc	s) should become totally disabled	
credit from Medicard, a division of iFinance Canada Inc. ("IFInance") and is warranted to be true and confined. 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 Signature of Applicant Date Date Approximate date of procedure Fixed Monthly Payments Please check one:										
Signature of Applicant Date Signature of Co-Applicant (if applicable) Patient's name (if applicable) Approximate date of procedure Fixed Monthly Payments Please check one:	credit from Me we hereby aut successors an or its successo of the Collecte agencies, and a a financial rela READ ADDITION	dicard, horize a ld assig ors and ld Inform amongs tionship NAL TER	a division of nd consent on sof whateversely may nation and a tiFinance, its or the solution of the solution o	to the collectiver credit investigation of the collectiver credit investigation of the collection of t	nada Inc. (ion of the estigations oriate from nformation and assign OW AND SI	"IF inance") and Collected Infori and/or employ time to time, a based thereor s or any compa	mation mation ment a ment a to the for the forth forth for the forth forth for the forth forth forth for the forth	ranted to be tru and to the maki and income conf he disclosure, sh ese purposes w whom I/we have	e and complete. In ng by iFinance, its irmations iFinance naring or exchange ith credit reporting or propose to have	
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\$ Please check one:	Signature of Applicant		Date		3	Signature of Co-Applicar	nt (if applica	able) Date		
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