Superior optical lab

DIGITAL PRECISION. HUMAN TOUCH.

New Account Form

Please Send To:

ecpsupport@superioroptical.com or

Fax to: 800-476-3937

Vision Care Direct

5/14/24

Date of Application:_____ Superior Rep: _____

Name of Business: _____

Billing Address: _____

City/State/Zip: _____

Shipping Address if Different Than Billing Address: _____

City/State/Zip: _____ Shipping Preference: FedEx ☐ UPS ☐

Business Phone: (Area Code _____)- _____

Business Fax: (Area Code _____)- _____ VSP ☐ VCD ☐ VBA ☐

Email for WIP Report: _____

Email for Statements (if different):_____

Primary Contact Name: _____

Below Information for primary location. For additional locations please only fill out the above information. Signature required for all forms submitted.

Federal Tax ID #: _____

Owners Name: _____

Home Address: _____

City/State/Zip: _____

Age of Business Under Current Ownership: _____

Requested Credit Amount _____

I agree for Superior Optical Lab to share Statement and Invoice information with VCD

Initial: _____

Terms, Conditions and Agreement:

In consideration for Superior Optical Labs, Inc. (SOL) extending credit to the business identified above for any materials and/or services after this date at the request of applicants or its agents, the undersigned individual hereby personally guarantees unconditionally and irrevocably the prompt payment of any sums now or hereafter owed to SOL, by business identified above whether said sums are due under open account. Any discount on a statement is valid only if statement is paid by due date. Balances over 30 days are subject to a 2 % per month service charge or 24% annually. Applicant agrees to pay all reasonable costs of collections on past due account including, but not limited to attorney's fees and agency fees. The laws of MS, County of Jackson, will govern actions.

Signature: _____ Printed Name: _____

Title: _____ Date: _____