



DEALER INFORMATION

Contact us at 800-606-0049 or fax 856-642-9917

Company Name: _____ Phone #: _____ Fax #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date Business Started: _____ Federal ID #: _____ # of Employees: _____ # of Sales Reps: _____ # of Offices: _____

E-Mail Address: _____ Contractor License #: _____ Corporation Partnership Proprietor

Are you listed in directory assistance: YES NO Which, if any, industry/trade organizations are you a member of: _____

Average Transaction Amount: _____ Who have you provided financing through in the past? _____

% Of Business Commercial: _____ Average # of Commercial Installs Per Month: _____ % of Sales Leased/Financed: _____

% Of Business Residential: _____ Average # of Residential Installs Per Month: _____ % of Sales Leased/Financed: _____

(1) Distributor's Name: _____ Contact: _____ Phone #: _____

How long have you done business w/ the distributor? _____ Primary Manufacturer: _____ High Credit: _____ Terms: _____

(2) Distributor's Name: _____ Contact: _____ Phone #: _____

How long have you done business w/ the distributor? _____ Primary Manufacturer: _____ High Credit: _____ Terms: _____

Company Policy Regarding Product Service: _____ Do you offer extended warranties? YES NO

BANK REFERENCE

Name of Bank: _____ Phone Number: _____

Contact Name: _____ Account Number: _____ Average 3 Month Balance: _____

PRINCIPAL INFORMATION

Name: _____ Title: _____ % of Ownership: _____ Social Security # _____

Home Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Title: _____ % of Ownership: _____ Social Security # _____

Home Address: _____ City: _____ State: _____ Zip: _____

By signing below, the undersigned individual as principal authorizes Horizon Keystone Financial, its designee, assigns or potential assigns, to review his/her business credit profiles provided above in considering this application and for the purpose of the update, renewal, or extension of credit to the applicant or the collection of any resultant accounts. A fax or photocopy of this authorization shall be valid as the original

Signature: _____ Signature: _____

FOR OFFICE USE ONLY

Sign Off: BRM _____ DSM: _____ APPROVED DECLINED DATE: _____

Please Fax Back to 856-642-9917