



UVCO(United Vision Corp.), New York Office
 213 West 35th Street, Suite 904, New York, NY 10001
T. 212-356-0010 **F.** 212-356-0028
E. info@uvcus.com **U.** www.uvco.net

ACCOUNT APPLICATION

DATE: / /

GENERAL CONTACT INFORMATION			
Company name including d/b/a:			Trade Style
Telephone:	Fax:	E-mail:	
Registered company address:			
City:	State:	ZIP Code:	
Date business commenced:		Tax ID number:	
Type of Business: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Others, Please Specify:			
BUSINESS AND CREDIT INFORMATION			
Primary billing address:			<input type="checkbox"/> Same as above
City:	State:	ZIP Code:	
How long at current address?			
Telephone:	Fax:	E-mail:	
Bank name:			
Bank address:		Telephone:	
City:	State:	ZIP Code:	
Type of account: <input type="checkbox"/> Savings <input type="checkbox"/> Checking		Account number:	
Routing number(ABA):		Branch Code:	
OWNER, OFFICER, AND PARTNER INFORMATION			
Name:	Title:	Name:	Title:
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Telephone:		Telephone:	
Social security number:		Social security number:	
BUSINESS/TRADE REFERENCES			
Company name:			
Address:			
City:	State:	ZIP Code:	
Telephone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:	State:	ZIP Code:	
Telephone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:	State:	ZIP Code:	
Telephone:	Fax:	E-mail:	
Type of account:			



POLICIES

The following policies and procedures were enacted to allow us to serve all of our valued customers with efficiency, accuracy and fairness. In following these procedures you allow us to reach our goal of having customer returns credited to your account within 14 days of our receiving the return. Should you have any questions regarding specific credits or any of our policies, please contact a customer care representative at 212-356-0010.

CREDIT AND RETURN POLICY

- Lenses returned for credit should be sent attention: United Vision Corporation via UPS or certified US Mail only. Lenses returned via any other carrier are sent at the account's own risk.
- Edged or dyed (tinted) lenses will not be accepted for credit unless defective.
- Merchandise must be returned within 14 days in original packaging, free from personal markings, in resale able condition and must be accompanied by the original invoice.
- Please write the reason for return on each invoice.
- Merchandise returned will be credited at its lowest selling price less a 20% restocking fee.

WARRANTY

- Scratch-resistant warranties do not cover lenses that have been abused or subjected to extreme conditions. Scratch warranty does not cover lenses damaged during the edging or dispensing process.
- Anti-refractive warranties are determined and covered by the company's inspection only
- Available for covered lenses one year from invoice date.
- The replacement pair will be billed in full.
- Submit the scratched lenses with copies of both the original and reorder invoices stating that the lenses are scratched under warranty.

ORDERS

- We highly recommend that all accounts use our electronic order forms. These forms have been designed to reduce errors, increase processing speed, and provide you with both the invoice # that will be assigned to the job and a copy for your files. Forms are available by contacting Customer Service at 212-356-0010. Please fax orders to 212-356-0028 or email orders to info@uvcus.com.
- Past due accounts are not eligible for promotions, special services or the ability to make orders. All accounts with balances more than 60 days will be put on credit hold until arrangements have been made with bookkeeping.
- Prices subject to change without notice.
- Minimum order: 30 pairs of FSV or 30 pieces of SFSV.

FORMS OF PAYMENT

- Check, Wire Transfer, Amex, Master, Visa and Discovery Cards.

CUSTOMER SERVICE & ORDERING

MONDAY — FRIDAY
9:00 AM - 6:00 PM
Phone: 212-356-0010
Fax: 212-356-0028
Email: info@uvco.net
Website: www.inovixlens.com

I hereby certify that the above information is true and correct and is provided for the purpose of obtaining credit and I hereby authorize United Vision of NY Corp. to receive bank account credit and/or trade reference information from any of the references listed above in connection with my account with United Vision of NY Corp. and release and hold harmless all providers of such information.

If is agreed that a late fee will be charged on accounts outstanding more than 30 days from the date of the invoice at the rate of 1.5% per months(18% per annum). I also agree to pay all costs, including attorneys' fees, if collection by legal action is required. The foregoing terms and conditions, including payment terms, the attached service agreement and rate sheet have been read by me and I agree to be bound thereby.

Print Name

Title

Signature

Print Name

Title

Signature



METHOD OF PAYMENT

Customers who choose to pay by check or wire transfer **must also supply a valid credit card number**; to ensure that the order will be processed. Credit card will not be charged unless the credit card box is checked.

CREDIT CARD **SECURE MY ORDER WITH THE CREDIT CARD** (CREDIT CARD WILL NOT BE CHARGED)

I _____ hereby authorize United Vision Corporation, to charge my credit card account in the amount not to exceed: \$ _____

Card Type: () Visa () Master Card () Discovery () Amex
Account Type: () Personal () Business () Government () International

Credit Card Number: _____ **Expiration Date:** _____ / _____ **Card identification number:** _____

_____ **Date:** _____ / _____ / _____

Cardholder's Name (Please Print)

Cardholder's Signature

As the credit card holder, I also authorize United Vision Corporation to charge my credit card for future purchases verbally approved by me. **Authorization Valid Until:** _____ / _____ **Initial Here:** _____
 Your completion of this **authorization form** helps us to protect you, our valued customers, from credit card fraud. United Vision Corporation will keep all information entered on this form **strictly confidential**.

CREDIT CARD BILLING ADDRESS

Street: _____

City: _____ **State:** _____ **Zip Code:** _____ - _____

Country: (if not US) _____ **Telephone: (** _____ **)** _____ - _____

BANK TRANSFER

Please note customers are responsible for any bank processing fees.

Please include \$15 for U.S customers (\$50 for international customers) for wire transfer fees charged by our banks.

Beneficiary Name:

United Vision Corp.

213 West 35th Street, Suite 904

New York, NY 10001, USA (Tel. 212-356-0010)

Bank Information:

TD Bank, N.A

469 7th Avenue

New York, NY 10018, USA (Tel. 212-244-7201)

Account No.: 7916990687

ABA No.: 026013673

Swift Code: CBNAUS33

COMPANY CHECK, CERTIFIED/BANK CHECK OR MONEY ORDER

Please make check payable to: **United Vision Corp.** Checks must be in U.S. funds drawn on a U.S or Canadian bank.