



FAX #1-807-223-3320
www.wilson.ca
PERSONAL ACCOUNT

LAST NAME _____ FIRST NAME _____

SOCIAL INSURANCE # _____ BIRTHDATE _____
(DD/MM/YYYY)

MAILING ADDRESS: _____ STREET ADDRESS (if different from mailing address) _____

HOW LONG AT THIS ADDRESS _____ TEL# _____

PREVIOUS ADDRESS _____

EMAIL ADDRESS _____

EMPLOYMENT DETAILS:

EMPLOYER _____ OCCUPATION _____

ADDRESS _____

PREVIOUS EMPLOYER _____ OCCUPATION _____

ADDRESS _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____

ADDRESS _____

BANK YOU DEAL WITH _____ HOW LONG _____

LOCAL CREDIT REFERENCES (do not list banks or credit cards)

PROVINCIAL SALES TAX EXEMPTION # (if applicable) _____

HAVE YOU OR YOUR SPOUSE HAD AN ACCOUNT WITH WILSON'S BEFORE (Y/N)_____

IF YES APPROXIMATELY HOW LONG AGO _____

HAVE YOU OR YOUR SPOUSE EVER FILED FOR BANKRUPTCY (Y/N)_____

IF YES PLEASE ADVISE DATE FILED _____

THE ABOVE INFORMATION IS FOR THE PURPOSE OF OBTAINING CREDIT AND IS WARRANTED TO BE TRUE. I AGREE TO PAY ALL BILLS UPON RECEIPT OF STATEMENT OR AS OTHERWISE EXPRESSLY AGREED. THE CREDIT TERMS OF NET 30 DAYS AFTER WHICH INTEREST AT 1.5 %/MONTH IS APPLIED, ARE ACCEPTABLE. I HEREBY AUTHORIZE THE PERSON OR FIRM TO WHOM THIS APPLICATION IS SUBMITTED TO OBTAIN SUCH CREDIT REPORTS OR OTHER INFORMATION AS MAY BE DEEMED NECESSARY IN CONNECTION WITH THE ESTABLISHMENT AND MAINTENANCE OD A CREDIT ACCOUNT OR FOR ANY OTHER DIRECT BSUINESS REQUIREMENT. THIS CONSENT IS GIVEN PURSUANT TO SECTION 12 OF THE PERSONAL INFORMATION ACT, S.B.C.1973.

DATE_____ SIGNATURE _____

WILSON'S REPRESENTATIVE _____

Please fax or e-mail the completed form to:

Wilson's Business Solutions
PO Box 3005, 32 King Street
Dryden ON P8N 2Z6
PH: 1-807-223-3316 FAX: 1-807-223-3320
E-Mail: accrepcaymts@wilson.ca