HEALTHSMART™
FINANCIAL SERVICES

Three Easy Steps

1) Note the clinic you will be attending
2) Complete the application in full
3) Submit the applications (to clinic or Health Smart Financial) along with 2 pieces of ID, one must be photo.

Application

*Mandatory Items

Approximate Cost of Program: ____________

*Name of Clinic: ____________

Personal Information

*First Name: ____________ *Last Name: ____________ Middle Initial: ____________

*Street #: ____________ *Street Name: ____________ Apt: ____________

*City: ____________ *Province: ____________ *Postal Code: ____________

*Housing Status: Own ☐ Rent ☐ R&B ☐ Family ☐ *Length at Address? ____________

If less than 1 1/2 years at this address, please enter your previous address.

*Street #: ____________ *Street Name: ____________ Apt: ____________

*City: ____________ *Province: ____________ *Postal Code: ____________

*Email Address: ____________ *Confirm Email: ____________

*Question For Lost Password: High School ☐ First Car ☐ Favourite Teacher ☐ *Answer: ____________

*Home Phone: ____________ Alternate Phone: ____________

*Date of Birth: ____________ Social Insurance Number: ____________

*Identification: ____________ *ID #: ____________

[1]Note: Cannot accept or record Ontario, Quebec or Manitoba Health Cards.

Employment & Financial Information

*Job Position: ____________

*Employer Name: ____________ *Gross Annual Salary: ____________ (Applicant Only)

*Job Start Date: ____________

*Work Phone: ____________ ext: ____________

If less than 1 1/2 years at this employer, please enter your previous employer.

*Employer Name: ____________ *Gross Annual Salary: ____________ (Applicant Only)

*Job Start Date: ____________ *Work Phone: ____________ ext: ____________

Terms and Conditions

I agree, represent and warrant that the information I have given Health Smart Financial Services™ on this application is complete and accurate and understand that Health Smart Financial Services™ is relying on the information. I authorize Health Smart Financial Services™ to collect credit, personal and other information provided on this application and from credit reporting agencies and other parties. I authorize the collection and exchange of information about investigations and/or employment and income references as Health Smart Financial Services™ may deem appropriate from time to time, and to sharing or exchange of reports or information with credit reporting agencies, or any company with whom I have or may propose to have a financial relationship.

By initialing here, the Borrower authorizes the Lender to disclose the Borrower's Credit Limit to your servicing clinic, and to disclose, throughout the term of this Agreement, the amount of credit available to the Borrower from time to time. ____________*initial here

Client Signature: ____________ Witness: ____________

Print Name: ____________ Date: ____________

When completed, please email to info@healthsmartfinancial.com or fax to 877.276.2227.