APPLICATION FOR CREDIT

Tel: 1-888-689-9876 Fax: 1-888-689-9862 medicard.com

APPLICANT'S INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐	First Name & Initial(s):	Last Name:	Date of Birth: (DD/MM/YY)
Home Number:	Work Number:	Cell Number:	Email:
Present Address: Apt #: City: Prov.: Postal Code:			How Long At This Address?
Own ☐ Rent ☐ Parents ☐	Monthly Rent or Mortgage: $	Mortgage Lender:	Social Insurance # (Optional):	Driver's License # + Province (Optional in Québec):
Occupation:	Present Employer (Company Name):	Contact Name:	Employer's Phone Number:	Length of Employment:
Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Student ☐	Gross Monthly Income: $	Other Income (Specify): $		
If Self Employed, State Name of Source of Income / Accountant:	Accountant's Phone Number:			

CO-APPLICANT'S INFORMATION (If any)

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐	First Name & Initial(s):	Last Name:	Date of Birth: (DD/MM/YY)
Home Number:	Work Number:	Cell Number:	Email:
Present Address: Apt #: City: Prov.: Postal Code:			How Long At This Address?
Own ☐ Rent ☐ Parents ☐	Monthly Rent or Mortgage: $	Mortgage Lender:	Social Insurance # (Optional):	Driver's License # + Province (Optional in Québec):
Occupation:	Present Employer (Company Name):	Contact Name:	Employer's Phone Number:	Length of Employment:
Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Student ☐	Gross Monthly Income: $	Other Income (Specify): $		
If Self Employed, State Name of Source of Income / Accountant:	Accountant's Phone Number:			

TERMS AND CONDITIONS

I/we understand that the above information (the "Collected Information") is being collected for the purpose of obtaining credit from Medicard, a division of Medicard Finance Inc., carrying on business as iFinance Canada Inc. ("iFinance") and is warranted to be true and complete. I/we hereby authorize and consent to the collection of the Collected Information and to the making by iFinance, its successors and assigns of whatever credit investigations and/or employment and income confirmations iFinance or its successors and assigns may deem appropriate from time to time, and to the disclosure, sharing or exchange of the Collected Information and any report or information based thereon for these purposes with credit reporting agencies, and amongst iFinance, its successors and assigns or any company with whom I/we have or propose to have a financial relationship.

If approved, iFinance will contact International Health Care Providers Inc.

X ____________________ Date ____________
Signature of Applicant

X ____________________ Date ____________
Signature of Co-Applicant (if applicable)

$ ____________________
Amount of Financing Required

____
Date of Financing

Fixed Monthly Payment (please check one):

◯ 6 months ◯ 1 year ◯ 2 years ◯ 3 years ◯ 4 years ◯ 5 years

See sample payment chart on reverse

International Health Care Providers Inc.
Tel. 519-736-0189

Please fax the completed application form to **1-888-689-9862**

MEDICARD Sample Monthly Payment Chart (lowest-highest) $ Canadian

Amount	5 years	4 years	3 years	2 years	1 year	6 Months
$1,000.00				49.89 - 56.59	94.19 - 100.79	182.94 - 189.87
$2,000.00	47.12 - 62.20	55.79 - 70.28	70.39 - 84.29	99.78 - 113.17	188.37 - 201.58	365.87 - 379.75
$3,000.00	70.68 - 93.31	83.69 - 105.42	105.58 - 126.44	149.67 - 169.76	282.56 - 302.37	548.80 - 569.62
$4,000.00	94.24 - 124.41	111.59 - 140.56	140.77 - 168.58	199.56 - 226.34	376.74 - 403.16	731.74 - 759.49
$5,000.00	117.80 - 155.51	139.48 - 175.70	175.97 - 210.73	249.45 - 282.93	470.93 - 503.95	914.68 - 949.36
$6,000.00	141.36 - 186.62	167.38 - 210.85	211.16 - 252.88	299.34 - 339.52	565.11 - 604.74	1097.61 - 1139.24
$7,000.00	164.92 - 217.72	195.28 - 245.99	346.35 - 295.02	349.23 - 396.10	659.30 - 705.53	1280.54 - 1329.11
$8,000.00	188.48 - 248.82	223.18 - 281-13	281.55 - 337.17	399.12 - 452.69	753.49 - 806.32	1463.48 - 1518.98
$9,000.00	212.04 - 279.92	251.07 - 316.27	316.74 - 379.32	449.00 - 509.27	847.67 - 907.11	1646.41 - 1708.86
$10,000.00	235.60 - 311.03	278.97 - 351.41	351.93 - 421.46	498.90 - 565.86	941.86 - 1007.90	1829.35 - 1898.73
$11,000.00	259.16 - 342.13	306.87 - 386.55	387.13 - 463.61	548.78 - 622.44	1036.04 - 1108.69	2012.28 - 2088.60
$12,000.00	282.72 - 373.23	334.76 - 421.69	422.32 - 505.75	598.67 - 679.03	1130.23 - 1209.48	2195.22 - 2278.48
$13,000.00	306.28 - 404.33	362.66 - 456.83	457.51 - 547.90	648.56 - 735.62	1224.42 - 1310.27	2378.15 - 2468.35
$14,000.00	329.84 - 435.44	390.56 - 491.97	492.71 - 590.05	698.45 - 792.20	1318.60 - 1411.06	2561.09 - 2658.22
$15,000.00	353.40 - 466.54	418.46 - 527.12	527.90 - 632.19	748.34 - 848.79	1412.79 - 1511.85	2744.02 - 2848.10

SIMPLE

1. **Fax the completed application form to: 1- 888-689-9862.**
2. You can request financing for a portion, or MEDICARD will finance the complete amount.
3. Upon financing approval, we will fax to you a loan disclosure statement with your exact monthly payment amount and credit terms.
4. You will need to fax us a copy of a void cheque with the signed disclosure statement to complete the financing process.
5. A confirmation of financing form will be sent to the **International Health Care Providers Inc.**
6. MEDICARD will pay the **International Health Care Providers Inc.** directly.
7. Your monthly loan payments are automatically debited from your chequing account.

Our office would be pleased to answer any questions or concerns that you may have.
Call 1-888-689-9876