



NEW ACCOUNT FORM

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Billing information	
Company name:	Branch #:
Address:	
Telephone #:	Fax #
In business since:	
Federal Tax ID# (IRS#):	
Shipping information (please attach a list of other locations)	
Name:	
Address:	
Telephone #:	Fax #
Primary buyer's name	E - E
Email address:	
Secondary buyer's name:	E - E
Email address:	
Accounts payable	
Please provide three (3) credit references.	
Contact name:	
Email address:	Fax #

*Do you wish to receive invoices by email? YES NO

INTERNAL USE ONLY		
Date:	Agent #:	Sub-agent #
Warehouse CAN:	Quebec <input type="checkbox"/>	Ontario <input type="checkbox"/> B.C. <input type="checkbox"/>
Warehouse USA:	Ohio <input type="checkbox"/>	Dallas <input type="checkbox"/>
Discount structure <input type="checkbox"/>	Resale certificate <input type="checkbox"/>	
Group #:	PPD: \$	Credit limit \$

****USA CUSTOMERS: PLEASE SEND US A COPY OF YOUR RESALE**
CERTIFICATE IF APPLICABLE IN YOUR LOCATION**

Please fill in this form, sign it and send it back to Sales.

Email: sales@bmicanada.com
Fax: 1-800-561-8579

X _____