

HOYA Vision Care North America

Date:	State:	Manufacturing Lab:
Account #:	Account Status: Account Transfer to Villavecchia Buying Group	
Account Name:		
Dr. Name:	Suf:	
Address:(ship to)		
City	State	Zip
*Courier:	*County	*State tax ID #
Contact:		
Phone #	Fax #	
Finished <input type="checkbox"/>	Uncut <input type="checkbox"/>	Both <input type="checkbox"/>
		VSP Work <input type="checkbox"/>

Bill To Information:

Buying Group <input checked="" type="checkbox"/>	Name of Buying Group: Villavecchia Buying Group	
Address of Buying Group		
Bill to Address:(if different from ship to)		
Address:		
City:	State:	Zip

Trade Reference(s) (preferably optical lab):

Company Name:	Company Name:
Account No:	Account No:
Phone No.	Phone No.
Contact Person	Contact Person

Company Name:	Company Name:
Account No:	Account No:
Phone No.	Phone No.
Contact Person	Contact Person

*Trade references and Tax id required if inactive for 6 months or if required by corporate office

Comments: **Please do not open a new account, tranfer to buying group only

PLEASE FAX THIS APPLICATION TO 972-436-9766

Hoya Representative: Date Submitted: