



Merchant Application

Phone/Fax: 877.711.9089

merchants@card-smith.com

Business/Store Information

Business/Store Name: _____

Store ID #: _____ Store Manager: _____

Physical Street Address 1: _____

Physical Street Address 2: _____

City: _____ State: _____ Zip Code: _____

Business Phone #: _____ Fax #: _____

Business Hours: _____ Business E-Mail: _____

Business/Store Web Site: _____

Average Sales/Ticket Amount: _____ Alcohol Sales: Yes _____ No _____

Corporate/Owner Information

Corporate Name: _____ Owner Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone #: _____ Fax #: _____

Email Address: _____

Payment Processing Account Information

Account Name: _____

Checking Account Address (Address on Check): _____

City: _____ State: _____ Zip Code: _____

Bank Name: _____

Routing Number: _____ Account Number: _____

Required for Payment Processing

← **Please Staple Your Voided Check Here**

Note: In lieu of a voided check please request your bank fax a letter to CardSmith at (877) 711-9089.

Sample letter:

Per the request of <Insert School Contact Name>, <Insert Bank Name> confirms the account number which will be used for the student debit card program is <Insert Account Number>. <Insert Bank Name's> routing number is <Insert Routing Number>.

Please Read & Initial: Merchant agrees to keep sufficient funds in the Designated Account to enable monthly automated fee collection (if applicable). Merchant authorizes CardSmith in accordance with the Agreement to initiate both debit and credit transfers to its Designated Account. Merchant is responsible for any bank charges resulting from ACH transactions rejected or returned for any reason and agrees to pay CardSmith a fee of \$25 per incident. (Please Initial Here) _____

* Initials required for application approval

Incorporation & Tax Information

State of Incorporation: _____ Federal Tax ID#: _____

Daily Operations Information

Daily Ops Contact Name: _____

Preferred Method of Contact: ___ Phone ___ Fax ___ Email (Please Specify Below if Different from Above)

Statement & Financial Contact Information

Send Statements to: ___ Store Address (pg. 1) ___ Corporate Address (pg.1)

Please select the financial contact: ___ Daily Ops (pg. 1) ___ Store Manager (pg. 1) ___ Owner (pg. 1)

___ Other (Please Specify and Complete Info Below) _____

Business Phone #: _____ Fax #: _____

Email Address: _____

Name and Title of Person Signing Application

Full Name (Last, First, MI): _____ Email Address: _____

Title: _____ Date: _____

Business Profile

Section 1: What category best fits your business?

___ Art Supply/ Music/ Specialty Store ___ Beauty/ Hair Care/ Tanning ___ Bookstore/ School Supply ___ Copy/ Mail/ Print Services ___ Doctor/ Dentist

___ Fast Food ___ Gas Station ___ Grocery/ Convenience Store ___ Gym/ Fitness/ Health Center ___ Hardware/ Repair Shops

___ Laundry ___ Movie/ Theater ___ Other Retail ___ Pharmacy/ Card & Gift Store ___ Restaurant

Section 2: If you are a restaurant, please select appropriate type(s) from the following:

___ Bakery/Bagels ___ Coffee ___ Deli ___ Delivery ___ Dine In

___ Ice Cream ___ Pizza ___ Quick Serve ___ Take Out ___ Other

Section 3: Terminal Settings:

Phone Jack for Use with Terminal: Yes; In Place _____ No; To Be Installed _____ Date Available for Installation: _____

Dial Prefix: Yes _____ No _____ If Yes, what is it? _____

Phone Line: ___ Dedicated Telephone Line ___ Shared with Fax/Other Terminal ___ Shared with Phone Line

Tip Acceptance: Y ___ N ___ If Yes: Suppress tip prompt at sale? Y ___ N ___ Per-cashier reporting? Y ___ N ___

Section 4: Terminal Lease or Purchase: ___ Lease ___ Purchase ___ Already Own

Logo/Graphic Submissions

If you would like your logo included on the Card Program Website, please submit the following:

- Logo in vector eps or native illustrator or freehand files (MAC or PC), OR
- Art in tif, jpg, eps, pdf, or psd files with resolution of at least 300 dpi at 2

Submitting Your Application

Upon completion, please fax or mail this application to:

Fax #: 877.711.9089

CardSmith

ATTN: Merchant Care

200 S. Clinton Street, 2nd Floor

Doylestown, PA 18901

Internal Use Only

Program ID:	Agreement Mailed:	Terminal Type:
Date Received:	Agreement Received:	
Date Approved:	Retail or Tip Application:	