INTERCONTINENTAL
KANSAS CITY
AT THE PLAZA

Attn: James Halloran – Controller
401 Ward Parkway, Kansas City, MO 64112 U.S.A.
(P) 816.303-2952 (F) 816.756-2874 (E) jhalloran@kansascityic.com

CREDIT APPLICATION

Name of Organization: _____

Type of Organization: _____

Billing Address: _____

_____

_____

Booking Contact: _____ Accounts Payable Contact: _____

Phone #: _____ Phone #: _____

Fax #: _____ Email _____

Please list individuals who are authorized to sign for charges against this account:

Name: _____ Position: _____ Signature: _____
Name: _____ Position: _____ Signature: _____
Name: _____ Position: _____ Signature: _____

Missouri State Sales Tax Exempt

☐ Yes
☐ No

If yes, please include a copy of group tax exemption certificate. If tax exemption certificate is not provided, group will responsible for payment of taxes until a valid tax exemption certificate is received by the hotel.

Estimated Amount of Event: $ _____ First scheduled event *(MM/DD/YY)*: _____

Direct Bill Credit with the Intercontinental Kansas City will only be issued for groups exceeding a $5,000.00 minimum.

CREDIT REFERENCES

In order to properly establish credit with the InterContinental Kansas City, we ask that you submit three (3) Hotel References with as much information as possible. If you are unable to provide three hotel references, please provide three (3) trade references that we may contact.

Company Name: _____ **Company Name:** _____
Address: _____ **Address:** _____
_____ _____
Contact Person: _____ **Contact Person:** _____
Phone #: _____ **Email:** _____ **Phone #:** _____ **Email:** _____
Dates of Stay: _____ **Account #:** _____ **Dates of Stay:** _____ **Account #:** _____

Company Name: _____ **Company Name:** _____
Address: _____ **Address:** _____
_____ _____
Contact Person: _____ **Contact Person:** _____
Phone #: _____ **Email:** _____ **Phone #:** _____ **Email:** _____
Dates of Stay: _____ **Account #:** _____ **Dates of Stay:** _____ **Account #:** _____

BANK INFORMATION

Institution: _____

Address: _____

Checking Acct #: _____ Savings Acct #: _____

Contact Person: _____ Phone #: _____

ALTERNATIVE METHOD OF PAYMENT (Required)*

Outstanding charges over 60 days will be charged to this credit card.

☐ Visa ☐ MasterCard ☐ American Express ☐ Diners ☐ Discover

Card #: _____

Expiration Date: _____ Name of Cardholder: _____

Billing Address of Cardholder: _____

Phone #: _____ Fax #: _____ Email: _____

AUTHORIZED CHARGES

If this section is not completed, ALL charges will be placed to the group Master Account.

☐ **ALL CHARGES** ☐ ROOM & TAX ☐ BANQUET

☐ RESTAURANT/BAR ☐ HONOR BAR ☐ DEPOSIT

☐ OTHER *Please Specify:* _____

I hereby authorize and direct that an investigation be made of these references, and agree to hold the InterContinental Kansas City harmless from any action arising out of the legitimate and proper conduct of those investigations. I (we) agree that the above named group, firm or individual shall pay the amounts due not later than 30 days following the invoice date. Accounts over 30 days will be subject to finance fees at an interest rate of 1.5%. I (we) further personally guarantee, unconditionally and irrevocably, the payment upon demand of all liabilities and obligations, to include all costs incurred in connection with the enforcement of this Guaranty. I (we) understand that credit accounts in good standing are open for one year and must be renewed annually.

_____ _____ _____

AUTHORIZED SIGNATURE: ***TITLE:*** ***DATE:***

HOTEL USE ONLY

Credit Manager

Estimated Amount of Function: $ _____ **Recommended Limit:** $ _____

Signature: _____

Controller ☐ **Approved** ☐ **Denied**

Signature: _____ **Recommended Limit:** $ _____

Comments: _____

General Manager ☐ **Approved** ☐ **Denied**

Signature: _____ **Approved Limit:** $ _____

Comments: _____