

## Commercial Loan Application

**\*\*\*Please note that verifiable assets, recent listing info, and REO schedule (page 2) are very important for loan evaluation and compensating factors so be sure to include if applicable**

| 1. FINANCING REQUEST                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                        |                                            |                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                        |            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Requested Loan Amount<br>\$ _____                                                                                                                                                                                                                                                                                     |                                                                                                                                                                        | Property Value<br>\$ _____                 |                                                                                                                                                                                                                                                                                                                                                                 | Purpose of Loan: <input type="checkbox"/> Purchase <input type="checkbox"/> Refinance<br>Type of loan: Flex I/O ARV Pro FlexTerm with I/O                              |            |
| 2. PROPERTY INFORMATION                                                                                                                                                                                                                                                                                               |                                                                                                                                                                        |                                            |                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                        |            |
| Subject Property Address:<br><br>Street: _____<br><br>City: _____ State: _____<br><br>Zip code: _____ # of Units: _____<br><br>Will title be held in an entity? <input type="checkbox"/> YES <input type="checkbox"/> NO<br><br>If YES, Entity Name: _____<br>Verifiable assets (checking/savings/401k/etc): \$ _____ |                                                                                                                                                                        |                                            | Property Type:<br><br><input type="checkbox"/> 1-4 residential units <input type="checkbox"/> 5+ residential units<br><br><input type="checkbox"/> Mixed use <input type="checkbox"/> Retail<br><br><input type="checkbox"/> Warehouse <input type="checkbox"/> Office<br><br><input type="checkbox"/> Auto service<br><br><input type="checkbox"/> Other _____ |                                                                                                                                                                        |            |
| Refinance: <input type="checkbox"/> Year acquired: _____ Cost: _____<br><br>Purchase: <input type="checkbox"/> Purchase Price: _____<br>Fix/Flip or Renovation? If yes, ARV is \$ _____                                                                                                                               |                                                                                                                                                                        |                                            | Most recent listing date if refi: _____ List Price: \$ _____<br>Improvements: <input type="checkbox"/> Made or <input type="checkbox"/> To be made<br><br>\$ _____                                                                                                                                                                                              |                                                                                                                                                                        |            |
| Does Applicant intend to live in the subject property for more than 14 days per year?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                     |                                                                                                                                                                        |                                            | Does Co-Applicant intend to live in the subject property for more than 14 days per year?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                            |                                                                                                                                                                        |            |
| 3. APPLICANT INFORMATION                                                                                                                                                                                                                                                                                              |                                                                                                                                                                        |                                            |                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                        |            |
| Applicant's Name: _____                                                                                                                                                                                                                                                                                               |                                                                                                                                                                        |                                            | Co-Applicant's Name: _____                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                        |            |
| SSN #: _____                                                                                                                                                                                                                                                                                                          | Phone Number: _____                                                                                                                                                    | DOB: _____                                 | SSN #: _____                                                                                                                                                                                                                                                                                                                                                    | Phone Number: _____                                                                                                                                                    | DOB: _____ |
| Marital Status:<br><input type="checkbox"/> Married<br><input type="checkbox"/> Unmarried                                                                                                                                                                                                                             | Residency Status:<br><input type="checkbox"/> US Citizen<br><input type="checkbox"/> Permanent Resident Alien<br><input type="checkbox"/> Non-permanent Resident Alien |                                            | Marital Status:<br><input type="checkbox"/> Married<br><input type="checkbox"/> Unmarried                                                                                                                                                                                                                                                                       | Residency Status:<br><input type="checkbox"/> US Citizen<br><input type="checkbox"/> Permanent Resident Alien<br><input type="checkbox"/> Non-permanent Resident Alien |            |
| Primary Residence (Street, City, State, Zip):<br>_____<br><br><b>Estimated mid FICO score:</b><br><input type="checkbox"/> Own <input type="checkbox"/> Rent Number of Years: _____<br>email address: _____                                                                                                           |                                                                                                                                                                        |                                            | Primary Residence (Street, City, State, Zip):<br>_____<br><br><b>Estimated mid FICO score:</b><br><input type="checkbox"/> Own <input type="checkbox"/> Rent Number of Years: _____<br>email address: _____                                                                                                                                                     |                                                                                                                                                                        |            |
| 4. Employment Information                                                                                                                                                                                                                                                                                             |                                                                                                                                                                        |                                            |                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                        |            |
| Employer Name: _____                                                                                                                                                                                                                                                                                                  | Yrs. On Job: _____                                                                                                                                                     | Employer Name: _____                       | Yrs. On Job: _____                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                        |            |
| Address (Street, City, State & Zip): _____                                                                                                                                                                                                                                                                            | Monthly Income: \$ _____                                                                                                                                               | Address (Street, City, State & Zip): _____ | Monthly Income: \$ _____                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                        |            |
| Business Phone: _____                                                                                                                                                                                                                                                                                                 | Self-employed: <input type="checkbox"/>                                                                                                                                | Business Phone: _____                      | Self-employed: <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                        |            |
| Position/Title/Type of work: _____                                                                                                                                                                                                                                                                                    |                                                                                                                                                                        | Position/Title/Type of work: _____         |                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                        |            |

## Commercial Loan Application

| 5. Real Estate Owned                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                                                                                                                                     |                   |
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| Property Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Type of Property | Current Value                                                                                                                                                                                                                                                       | Existing Mortgage |
| 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | \$                                                                                                                                                                                                                                                                  | \$                |
| 2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | \$                                                                                                                                                                                                                                                                  | \$                |
| 3.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | \$                                                                                                                                                                                                                                                                  | \$                |
| 4.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | \$                                                                                                                                                                                                                                                                  | \$                |
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| 7.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | \$                                                                                                                                                                                                                                                                  | \$                |
| 8.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | \$                                                                                                                                                                                                                                                                  | \$                |
| 9.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | \$                                                                                                                                                                                                                                                                  | \$                |
| 10.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | \$                                                                                                                                                                                                                                                                  | \$                |
| 6. Agreement & Acknowledgement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                                                                                                                                     |                   |
| <p>Each of the undersigned specifically represents to Lender and to Lender's actual or potential agents, brokers, processors, attorneys, insurers, servicers, successors and assigns and agrees and acknowledges that: (1) the information provided in this application is true and correct as of the date set forth opposite my signature and that any intentional or negligent misrepresentation of this information contained in this application may result in civil liability, including monetary damages to any person who may suffer any loss due to reliance upon any misrepresentation that I have made on this application, and/or in criminal penalties including, but not limited to, fine or imprisonment or both under the provisions of Title 18, United States Code, Sec. 1001, et seq.; (2) the loan requested pursuant to this application (the "Loan") will be secured by a mortgage or deed of trust on the property described in this application; (3) the property will not be used for any illegal or prohibited purpose or use; (4) all statements made in this application are made for the purpose of obtaining a business purpose mortgage loan; (5) the property will be occupied as indicated in this application; (6) the Lender, its servicers, successors or assigns may retain the original and/or an electronic record of this application, whether or not the Loan is approved; (7) the Lender and its agents, brokers, insurers, servicers, successors, and assigns may continuously rely on the information contained in the application, and I am obligated to amend and/or supplement the information provided in this application if any of the material facts that I have represented should change prior to closing of the Loan; (8) in the event that my payments on the Loan become delinquent, the Lender, its servicers, successors or assigns may, in addition to any other rights and remedies that it may have relating to such delinquency, report my name and account information to one or more consumer reporting agencies; (9) ownership of the Loan and/or administration of the Loan account may be transferred with such notice as may be required by law; (10) neither Lender nor its agents, brokers, insurers, servicers, successors or assigns has made any representation or warranty, express or implied, to me regarding the property or the condition or value of the property; and (11) my transmission of this application as an "electronic record" containing my "electronic signature," as those terms are defined in applicable federal and/or state laws (excluding audio and video recordings), or my facsimile transmission of this application containing a facsimile of my signature, shall be as effective, enforceable and valid as if a paper version of this application were delivered containing my original written signature.</p> <p><b>Acknowledgement:</b> Each of the undersigned hereby acknowledges that any owner of the Loan, its servicers, successors and assigns, may verify any information contained in this application or obtain any information or data relating to the Loan, for any legitimate business purpose through any source, including a source named in this application or a consumer reporting agency.</p> |                  |                                                                                                                                                                                                                                                                     |                   |
| Applicant Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Date:            | Co-Applicant Signature                                                                                                                                                                                                                                              | Date:             |
| <b>X</b> _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | <b>X</b> _____                                                                                                                                                                                                                                                      |                   |
| 7. Government Monitoring Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                                                                                                                                     |                   |
| <p>The following information is requested by the Federal Government for certain types of loans related to a dwelling in order to monitor the lender's compliance with Equal Credit Opportunity, Fair Housing and Home Mortgage Disclosure laws. You are not required to furnish this information, but are encouraged to do so. The law provides that a lender may not discriminate either on the basis of this information, or on whether you choose to furnish it. If you furnish the information, please provide both ethnicity and race. For race, you may check more than one designation. If you do not furnish ethnicity, race, or sex, under Federal regulations, this lender is required to note the information on the basis of visual observation and surname if you have made this application in person. If you do not wish to furnish the information, please check the box below.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                                                                                                                                     |                   |
| Applicant: <input type="checkbox"/> I do not wish to furnish this information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | Co-Applicant: <input type="checkbox"/> I do not wish to furnish this information                                                                                                                                                                                    |                   |
| <b>Ethnicity:</b><br><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | <b>Ethnicity:</b><br><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino                                                                                                                                                    |                   |
| <b>Race:</b><br><input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American <input type="checkbox"/> White<br><input type="checkbox"/> Native Hawaiian or Other Pacific Islander                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | <b>Race:</b><br><input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American <input type="checkbox"/> White<br><input type="checkbox"/> Native Hawaiian or Other Pacific Islander |                   |
| <b>Sex:</b><br><input type="checkbox"/> Female <input type="checkbox"/> Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | <b>Sex:</b><br><input type="checkbox"/> Female <input type="checkbox"/> Male                                                                                                                                                                                        |                   |