ActivHealthCare™
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AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

I (we) hereby authorize ActivHealthCare, Inc, hereinafter called "Activ", to initiate CREDIT entries to my (our) CHECKING or SAVINGS account as indicated below at the depository financial institution named below, hereafter called FINANCIAL INSTITUTION, and initiate adjustments (if necessary) for any transactions debited or credited in error. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

1) Business Tax I.D number: _____

2) Form will apply EFT enrollment to all providers listed below. (Please Print)

1) _____ 2) _____

3) _____ 4) _____

3) Financial Institution **Name**: _____

4) Type of account: Circle one - **Checking Account** or **Savings Account**:

5) Provide the name as it appears on the business bank account. This should be on your checks and statements.

_____

6) **Routing Number:** _____ **Account number:** _____

8) Email addresses to which notifications will be sent.

Email 1:_____

Email 2:_____

9) Have the **AUTHORIZED SIGNER** of the business account sign, print name, list title and date below.

Signature_____ **Date**_____

Name _____ **Title**_____
(Please Print) **(Please Print)**

If required by your bank, please have a 2nd **AUTHORIZED SIGNER** of the business account sign, print name, list title and date below.

Signature_____ **Date**_____

Name _____ **Title**_____
(Please Print) **(Please Print)**

This authorization is to remain in full force and effect until Activ has received 30 day written notification of termination of this authorization and is required from me (or either of us) of its termination in such time and in such manner as to afford Activ and FINANCIAL INSTITUTION a reasonable opportunity to act on it.