ACH Authorization Form

This form **MUST** be accompanied by a **Printed Voided Check or Bank Letter**

Name: ____
Address:____
City:___________________________________State:________Zip:_________
Phone:___________________________________

Funds Settlement Information

Bank Name:____
Account Owner:____
Account Name:____
Address:____
City:___________________________________State:________Zip:_________
Routing # (9 digits) ____________________
Account #____

_________________________________ (hereinafter referred to as Health Merchant) authorizes The Green PolkaDot Box, Inc. or its designated assignee (hereinafter referred to as The Green PolakDot Box, Inc.), to initiate ACH transfer entries and to credit and/or debit the account identified herein for commissions relating to The Green PolkaDot Box, Inc. services. This authorization shall remain in effect unless and until The Green PolkaDot Box, Inc. has received written notification from Health Merchant that this authorization has been terminated in such time and manner to allow The Green PolkaDot Box, Inc. to act. Undersigned represents and warrants to The Green PolkaDot Box, Inc. that the person executing this Release is an authorized signatory on the Account referenced above and all information regarding the Account and Account Owner is true and correct.

____ / / ________
Account Owner Signature Date

____
Print Name and Title

ATTACH PRE-PRINTED VOIDED CHECK
OR
BANK LETTER

Email: Accounting@greenpolkadotbox.com
Please Fax to Accounting at 877-663-2217