ACH ENROLMENT/CHANGE AUTHORIZATION FORM

This is to notify ROE Dental Laboratory, Inc. and/or one or more of its subsidiaries and affiliates (herein collectively called ROE) of enrollment or change in EFT/ACH banking instructions for the Company (name stated below) herein referred to as Company. Therefore Company authorizes ROE to debit the noted account for accepting payments for goods and services by ACH. In the event of any duplicate payment, overpayment, fraudulent payment or payment made in error, the receiving party will immediately return such payment upon confirming the occurrence of any of the foregoing.

Customer / Payer Information

_____

Legal Entity Name, Name on Bank Account

_____

Doing Business as Name (If different from legal entity name)

_____

Physical Address, Address on File with Bank

_____ _____ _____

City ***State*** ***Zip Code***

_____ _____ _____

Accounts Payable Contact Name ***Contact Phone Number*** ***Email for Confirmation Notices***

Financial Institution Information

_____

Name of Financial Institution

_____

Address of Financial Institution

_____ _____

9 Digit Routing (ABA) Number (Domestic ACH) ***Account Number***

APPROVAL FOR ACH PAYMENT

_____ _____

Customer Signature ***Print Name***

_____ _____

Title ***Phone Number***