Electronic Payment Authorization Agreement

Request Type:

select one: ☐ ACH (*PREFERRED*) ☐ Wire

select one: ☐ NEW Request ☐ CHANGE Request ☐ CANCEL Request

Business/Individual Information:

Name: ______________________________

Physical Address: ______________________________

Email Address: ______________________________

Phone Number: ______________________________

If Business, Authorized Person Completing this Form: ______________________________

If Business is a Licensed Insurance Producer, Producer Number: ______________________________

If Business, Tax ID: ______________________________

Bank Information:

Name on Account: ______________________________

Bank Name: ______________________________

9 Digit Routing Number: ______________________________

Account Number: ______________________________

Account Type (select one): ☐ Business ☐ Personal | (select one): ☐ Checking ☐ Savings

If Changing Bank Information, Last 4 of Previous Account Number: ______________________________

Certification and Authorization:

This form is for Businesses/Individuals utilizing US bank accounts. Do not fill out this form if you require an international payment.
I certify that: (1) the Business/Individual has a US bank account; (2) the information provided on this form is correct; (3) the bank account designated above is enabled for ACH transactions (as defined below) and free of any debit blocks (applicable only for ACH transactions); and (4) I am authorized to complete this form on behalf of such business (applicable only for business accounts). I understand it is my responsibility to provide ample time of notice to MedPro of any changes to the information I have provided in this form. Such notice must be sent securely to **ach@medpro.com** for processing.

I hereby instruct and authorize MedPro Group Inc. and its subsidiaries and affiliates ("MedPro") to: (1) initiate any necessary electronic credit, debit and/or adjustment transactions ("ACH transactions") to the bank account designated above in connection with my professional relationship with MedPro (applicable only for ACH transactions); and (2) validate the information I have provided in this form, which, for individuals, could include MedPro obtaining information that is considered a consumer report under the Fair Credit Reporting Act. I understand this instruction and authorization will remain in full force and effect until such time that MedPro has received written notification requesting a change or cancellation, and MedPro has had a reasonable opportunity to implement such request. I further understand that, notwithstanding this instruction and authorization, MedPro reserves the right, in its sole discretion, to cease electronic payment transactions at any time in lieu of another payment method. I agree to indemnify and hold MedPro and its employees and directors harmless from and against any loss, claim, damage or liability arising out of or resulting from any action taken by MedPro in reliance upon the information provided under this form that MedPro, in good faith, believes to be genuine. Both parties agree to comply fully with the provisions of all U.S. laws, rules, and regulations, including, but not limited to, those set for by the National Automated Clearing House Association (NACHA).

Printed Name: ______________________________

Signature: ______________________________ Date: ______________________________

This form must be completed in its entirety. An incomplete form may not be accepted and will cause processing delays.

Return completed form securely via email to: **ach@medpro.com**