Electronic ACH Request Form

AUTHORIZATION AGREEMENT



I hereby authorize The Advertising Checking Bureau Inc. (ACB) on behalf of Ascensia Diabetes Care US Inc. (Ascensia) to initiate automatic electronic deposits to my account at the financial institution named below.

I also authorize **ACB** to make withdrawals from this account, if necessary, in the event of erroneous credit entry.

Further, I agree not to hold ACB or Ascensia responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This Authorization Agreement will remain in full force and effect until I notify ACB in writing that I wish to revoke this authorization, or ACB receives written notice from my financial institution, or until I submit a new Authorization Agreement to ACB.

Transfer Funds to:	**All fields are Required			
Customer Financial Institution Name	City		State	Country
Customer A.B.A. Routing Number	Customer Checking Accoun	t Number		
Ascensia Pharmacy Number (Please copy and	d paste this number directly fron	n your approval email from Ascens	ia)	
Customer Name or Account Name				
Customer Address				
Optional: Details of payment (e.g. invoice nu	mber, reference number, payme	nt for, by order of)		
Customer Name		Title		
Signature		Date		

**All fields are Required

When completed, please upload this form, including a copy of a check or deposit slip, to the ACH Authorization Agreement website https://ascensiaportal.acbrewards.com/DirectDepositRequest.aspx where you obtained the form.

Do not forget to hit the "submit" button after you have uploaded the file.

For customer service support, please contact MPBrebateprogramACB@ascensia.com