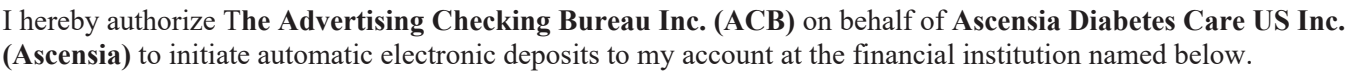


AUTHORIZATION AGREEMENT



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**.

*****All fields are Required***

Customer A.B.A. Routing Number Customer Checking Account Number

Ascensia Pharmacy Number (Please copy and paste this number directly from your approval email from Ascensia)

Customer Name or Account Name

Customer Address

Optional: Details of payment (e.g. invoice number, reference number, payment for, by order of)

Customer Name	Title
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Signature _____ Date _____

When completed, please upload this form, including a copy of a check or deposit slip, to the ACH Authorization Agreement website <https://ascensiportal.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