VIVIO

ACH VENDOR PAYMENT AUTHORIZATION FORM

This form is used for Automated Clearing House (ACH) payments. The information being collected on this form will be used by VIVIO Health, Inc. to transmit payment data, by electronic means, to your financial institution. Failure to provide the requested information may delay or prevent the receipt of payment through ACH Payment System. Recipients of the payments should bring this information to the attention of their financial institution when presenting this form for completion. **Recipients should also request to be notified immediately regarding any change occurring at the financial institution that may delay or prevent the receipt of scheduled payments.**

VENDOR INFORMATION

NAME :_____

ADDRESS :_____

CONTACT NAME :_____

CONTACT EMAIL & PHONE:_____

ACCTS REC. / CLAIM REMITTANCE EMAIL: _____

FINANCIAL INSTITUTION INFORMATION

BANK NAME:_____

BANK ADDRESS:_____

(9) DIGIT ROUTING NUMBER:_____

DEPOSITOR ACCOUNT NAME:_____

DEPOSITOR ACCOUNT NUMBER:_____

TYPE OF ACCOUNT: □ CHECKING □ SAVINGS

I, the undersigned, authorize VIVIO Health, Inc. to deposit funds directly to the account indicated above and to correct any errors which may occur from the transactions. I also authorize the financial institution named above to post these transactions to that account. This authorization will remain in force until VIVIO Health, Inc. receives written notice of cancellation from me and has reasonable time to act upon it. I acknowledge my responsibility to promptly notify VIVIO Health of any changes to our banking relationship and accept responsibility for not doing so in a timely manner.

_____ _____

SIGNATURE DATE

_____

NAME

_____

TITLE