Attn: Accounts Payable
P.O. Box 30058
Washington, DC 20030
info@FreeformWellnessAdvantage.com

ACH ENROLLMENT FORM

Information As part of our continuing efforts to provide excellent service to our valued partners, we are pleased to offer you the option of payments via automated clearinghouse (ACH).

Why Should You Enroll?

You will streamline your receivables process because funds will be automatically deposited into your account within two to four business days. This frees your staff's time and gives you access to your money sooner, as you will no longer need to wait for a check deposit to clear.

How Does It Work?

To enroll in the program, complete the following ACH enrollment form and return it to the address on the form. Once your application is approved, you will be eligible for payment via ACH within 15 business days.

Please continue to submit your invoices as you currently do today; payment via ACH will not affect the invoice submission process.

If you have any questions, please do not hesitate to contact our Accounts Payable department directly at:

FreeForm Wellness Advantage, LLC
Attn: Accounts Payable Department
Email: info@FreeformWellnessAdvantage.com
Phone: (202) 827-9760

Freeform
Wellness Advantage, LLC

Provider ACH Enrollment Form

Return completed form via email to: info@FreeformWellnessAdvantage.com **or** mail to: Freefrom Wellness Advantage, LLC P.O. Box 30058, Washington, DC 20030

Instructions: Please complete the fields below, sign and return the form to our provider relations department. Fields highlighted in yellow may be filled out electronically prior to printing. Forms may be returned via email or standard mail.

PROVIDER INFORMATION

Vendor Name: Federal Taxpayer ID:

Account Status (Check One): ☐ New Account Set Up ☐ Change Account Profile

Primary Contact Name: Primary Contact Phone/Email:

BANK INFORMATION

Account Type: ☐ Checking ☐Savings ☐ Other; Please Describe:

Bank Name:

Bank Routing Number:

Bank Account Number/IBAN:

Bank City & State:

AUTHORIZATION

Please enroll the vendor indicated above (the "Provider") in the FreeForm Wellness Advantage, LLC ACH disbursement program. I certify that I am an authorized representative of the Provider and that I have the authority to authorize receipt of payment on the Provider's behalf. The Provider agrees to hold FreeForm Wellness Advantage, LLC harmless and agrees to reimburse the FreeForm Wellness Advantage, LLC for all penalties and fees incurred as a result of any delay or failure by the Provider to receive payment caused by any inaccuracy, ambiguity or omission of any kind whatsoever in the bank account data submitted by the Provider above. The Parties acknowledge that the origination and receipt of ACH transactions to the account set forth above must comply with the provisions of U.S. law. This authorization will remain in full force and effect until the Provider or FreeForm Wellness Advantage, LLC has received written notice e of its termination from the terminating party in such time and manner as to afford the other party and financial institution(s) a reasonable opportunity to act upon said termination request.

Authorized Vendor Signature Date

Print Name Title

Accounting Use Only

Provider ID: Date Updated:

Updated By: Comments: