AblePay®
SIMPLE HEALTH SAVINGS

Authorization to Withdraw Funds from Checking Account

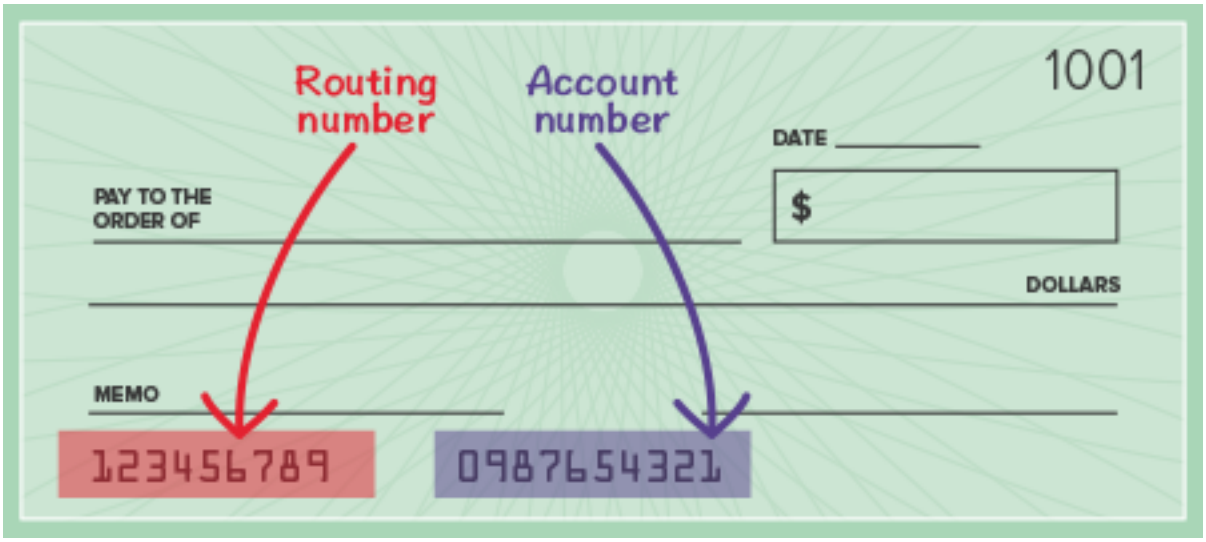
Please print and complete ALL the information below.

Company Name: _____

Company Contact: _____ Phone #_____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

Confirm Account #: _____

9-Digit Routing #: _____

Please attach a voided check for the bank account to which funds can be withdrawn.

AblePay Health LLC is hereby authorized to withdraw from the account listed above. This authorization will remain in effect until written notice is received cancelling it.

Authorized Signature: _____

Date: _____