CDPHN ACH AUTHORIZATION

The undersigned ("Customer") hereby authorizes Capital District Physicians' Healthcare Network, Inc. (CDPHN), to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any excess debit entries or debit entries made in error, to Customer's account indicated below and the depository named below, to debit and/or credit the same such accounts.

This authority is to remain in full force and effect until terminated by mutual agreement of the parties.

COMPANY NAME _____

GROUP NUMBER _____

TYPE OF ACCOUNT ◯ checking ◯ savings

◯ INITIATE ACH FOR NEW PLAN

◯ UPDATE ACH UPON RECIEPT

◯ UPDATE ACH EFFECTIVE _____ (Date)

◯ NO CHANGE *(Renew plan with same banking information)*

DEPOSITORY NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE NUMBER: _____

ROUTING TRANSIT NUMBER: _____

ACCOUNT NUMBER: _____

("CUSTOMER")

By: _____

Name: _____

Title: _____

ALEGEUS ACH AUTHORIZATION

The undersigned ("Customer") hereby authorizes Alegeus, LLC ("Alegeus"), to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any excess debit entries or debit entries made in error, to Customer's account indicated below and the depository named below, to debit and/or credit the same such accounts.

This authority is to remain in full force and effect until terminated by mutual agreement of the parties.

DEPOSITORY COMPANY NAME _____

GROUP NUMBER _____

TYPE OF ACCOUNT ◯ checking ◯ savings

◯ INITIATE ACH FOR NEW PLAN

◯ UPDATE ACH UPON RECIEPT

◯ UPDATE ACH EFFECTIVE _____ (Date)

◯ NO CHANGE *(Renew plan with same banking information)*

DEPOSITORY NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE NUMBER: _____

ROUTING TRANSIT NUMBER: _____

ACCOUNT NUMBER: _____

("CUSTOMER")

By: _____

Name: _____

Title: _____