Health Merchant Recurring Credit/Debit Authorization Form

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Email:_____
Store Name:_____

I authorize Green PolkaDot Box, LLC; or its designated assignee (hereinafter referred to as "GPDB"), to initiate recurring credit and/or debit entries to and/or from my account with the Financial Institution indicated below in regards to commissions, fees, or other charges relating to GPDB services as they become due and payable under the terms and conditions of the Health Merchant Agreement.

Payments in the amount of $_____ will be withdrawn from my account on the 1st of the month. If that day falls on a weekend or bank holiday, the withdrawal shall occur on the next business banking day. The effective date of the first payment is ____/____/____.

This authorization shall remain in effect unless and until GPDB has received written notification that this authorization has been terminated. Undersigned represents and warrants to GPDB that the person executing this Release is an authorized signatory on the Account referenced below and all information regarding the Account and Account Owner is true and correct.

Funds Settlement Information

Name on Account:_____
Bank Name:_____
Bank Address:_____
City:_____ State:_____ Zip:_____
Routing #:_____ Account #:_____
Type of Account: Checking ☐ Savings ☐

_____ ____/____/____
Authorized Signature Date

_____
Print Name and Title

ATTACH PRE-PRINTED VOIDED CHECK OR BANK LETTER

Remit to: healthmerchantservices@greenpolkadotbox.com or Fax (877) 663-2217

If you should need to notify us of your intent to cancel and/or revoke this authorization you must contact us 60 days prior to the questioned debit being initiated. Please call (877) 655-2368 or email healthmerchantservices@greenpolkadotbox.com Monday thru Friday from 8 AM to 5 PM MST.