CVSHealth

☐ NEW
☐ CHANGE

Dear Valued Supplier:

Attached is our ACH application. Please take a moment to review the following instructions.

1) Please complete the attached forms. An electronic signature will not be accepted.
2) Please provide a voided check copy or bank verification letter. ACH will not be established without this documentation. Note: The bank letter cannot be more than a year old.

Please return completed forms to the business person who sent you the form:

ACH Payment Add or Account Change Request

The following information is required for CVS Health to initiate ACH payments or change existing ACH payment bank routing-account information.

CVS Health Supplier Name _____

CVS Health Vendor # _____ Federal Tax ID# _____

Payment Terms: Current _____ New _____

CHECK REMITTANCES

Old Remittance Address:

Remit Name _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____

Zip Code _____

CORRESPONDENCE INFORMATION

Contact Name _____

E-Mail Address _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ Zip Code _____

Telephone # _____

ACH ELECTRONIC PAYMENTS

Old Account/Bank Information:

Bank Name _____

Bank Address _____

Address Line 2 _____

City _____

State _____ Zip Code _____

Routing/ABA # _____

Account # _____

Payee Name _____

Payee Address _____

New Account/Bank Information:

Bank Name _____

Bank Address _____

Address Line 2 _____

City _____

State _____ Zip Code _____

Routing/ABA # _____

Account # _____

Payee Name _____

Payee Address _____

COMPANY PAYMENT DETAILS (SELECT ONE)
How you will receive your payment details

☐ **CTX:**
Electronic Format (Your Bank must have an electronic A/R system)
Our bank sends the detail to your bank electronically, which in turn sends it to you electronically.

☐ **CCP:** (choose an option below)

☐ **Paper Remittance:** Our bank will mail the remittance detail to the mailing address provided below.
Payment Mailing Address **(as shown on invoice, number, street, floor, suite)**

☐ **E-Mail Format:** Our bank will e-mail the remittance detail to the e-mail address provided below:
Sent by grsp-aetnaap@maf.xpedite.com **E-mail address:** _____

Requester's Name _____

Requester's Title _____

Requester's Telephone Number _____

Requester's E-mail Address _____

CVS Business to Complete:

CVS Health Business Contact Name: _____

Verbal Confirmation Name: _____Phone # _____

CVSHealth

International ACH Transaction Rules

In connection with certain processing requirements for electronic supplier payments that are sent to a financial institution outside of the United States, CVS Health Corporation needs to know whether our payments to you are being forwarded from a United States financial institution to a financial institution in another country.

The particular rules are referred to as "International ACH Transaction (IAT) rules" and are pursuant to requirements of the Office of Foreign Assets Control.

In order for CVS Health Corporation to comply with the IAT rules and the applicable United States laws, you are requested to complete the "IAT Payee Affirmation Statement" below and return it with the ACH application. Failure to complete and promptly return the Affirmation Statement will make you ineligible to receive payments electronically.

IAT Payee Affirmation Statement

I represent that I have all requisite power, authority and capacity to execute this IAT Payee Affirmation Statement on behalf of my business. In addition, I acknowledge that electronic payments to the designated account for my business must comply with the provisions of United States law, as well as the requirements of the Office of Foreign Assets Control (OFAC).

Please check one of the following:

☐ I affirm that, regarding electronic payments that CVS Health Corporation may remit to the financial institution for credit to the account that I have designated, the entire payment amount **is not** subject to being transferred to a foreign bank account.

☐ I affirm that, regarding electronic payments that CVS Health Corporation may remit to the financial institution for credit to the account that I have designated, the entire payment amount **is** subject to being transferred to a foreign bank account. I understand that any payments that may be remitted to my business in the future may be labeled with "IAT" as the standard entry class. I also understand that CVS Health Corporation may elect to remit future payments to my business in any manner that it deems necessary to comply with the IAT rules.

Please note that by signing this IAT Payee Affirmation Statement, you agree to notify CVS Health Corporation promptly in the event that the selection above is no longer correct.

_____ _____

Signature Date

_____

Print Name and Title