Dear Valued Supplier:

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

1) Complete attached forms
2) In order to go on ACH payments, CVS Health requires additional days on vendor terms so that CVS Health remains mail float neutral.
3) Payment due date calculation will be based from receipt of goods into our distribution center or retail store.
4) CVS Health does not recognize cash in bank terms.
5) Do not fill out the section that the bank is to complete on page 2. CVS Health must initiate and expedite the release form to the bank and have them complete this section to verify the information that has been provided. The bank then needs to return the verified form to CVS Health.
6) Ensure that you have a valid bank location listed on page 1 so that CVS Health may verify the business address. P.O. boxes are not acceptable. Page 2 should contain the correct mailing address of your banking officer.
7) Please make sure an officer from your company completes the “Release of Information” section.
8) List all of the vendor numbers that will be set up on ACH with their corresponding terms on page 3.
9) Complete the IAT Payee Affirmation Statement

If you have any questions, please contact your CVS Accounts Payable Specialist.

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. The *Release of Information* section must be completed and authorized by an officer of your company recognized by your bank to release confirmation of the information provided by your company. Cash in bank terms are not recognized by CVS Health and all payment terms are from receipt of product into our distribution center or retail store.

CVS Supplier Name _____

CVS 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 _____

Requester's Name _____

Requester's Title _____

Requester's Telephone Number _____Requester's E-mail Address _____

CVS APPROVAL

CVS AP Manager _____ Date _____

ACH Payment Add or Account Change Request *(Page 2)*

Bank Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Cash Management/Credit Relationship Officer _____

Phone Number_____

Fax Number _____ Email Address _____

Bank to Complete:

To Whom It May Concern:

CVS Health has obtained authorization as referenced below (*Release of Information*) from an officer of _____ to confirm the information provided on Page 1 of this request under the *New Account/Bank Information* section for the purpose of validating that CVS Health funds transmitted to this account will be credited to the proper CVS Health supplier. Please complete the following by checking one**:**

The information supplied is correct ( ); or is not correct ( )

Confirming Bank Employee Name _____

Your Title _____

Your Telephone Number _____

Supplier to Complete:

Release of Information

I hereby authorize (New Bank) _____ to release information confirming the ownership of the above referenced New Account/Bank Information to CVS Health for the purpose of validating the authenticity of this request to direct funds to this banking institution on behalf of (CVS Health Supplier Name) _____.

Officer Name _____ Officer Signature _____

Officer Title _____ Date _____

Warehouse Vendor Information

PO Vendor Number	Current Vendor Terms	New Vendor Terms

International ACH Transaction Rules

In connection with certain processing requirements for electronic vendor 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