EFT Program

* **No Cost**
* **Eliminates paying with cash, checks or money orders**
* **Quick and easy sign-up**
* **Available for customers with one delivery location only**

EFT Enrollment Form: All information on this form is required

Customer Name (Company):	☐ New Customer ☐ Updated Bank Account
Mailing Address:	Location Address ☐ same as mailing
Company Phone:	Company Fax:
Primary Contact Name:	Company Federal Tax ID:
Contact Phone:	Contact E-mail:

Please attach a voided check on a separate page*

Bank Name:

Account Number:

ABA Transit/Routing Number (always 9 digits)

Account Type: Checking ☐ Savings ☐
Payment Terms: Net Zero ☐ 5 Days ☐ 10 Days ☐
Net 15 will be assumed if no box is checked above

The undersigned on behalf of Company hereby authorizes Triangle Distributing (Distributor) and its electronic funds service providers, including authorized banks, to use invoice information to initiate debit/credit entries for irrevocable payment for goods and services rendered by Distributor as designated (including the initiation of adjusting debits/credits for entries made in error or entries requiring reversals due to returned items) and for any other purpose related to the invoice information. All entries shall be made to the Company account shown above. Company agrees to fund the account adequately and guarantees to Distributor that sufficient funds will be available in the account to cover such debits/credits. Company agrees to acept such debits/credits and not to block access to the accounts.

This authorization is to remain in full force and effect until Company has provided written authorization for its termination at such time and in such manner so as to afford Distibutor, its electronic funds service providers and Company's bank a reasonable opportunity to act on it. Company and the undesigned each represent and warrant that they are authorized and empowered to execute this authorization for the purposes specified herein. Company agrees to indemnify and hold Distributor and its electronic funds service providers harmless from any damage, loss or claim resulting from Distributor's authorized actions hereunder.

Primary Authorized Signature (must be a signer on the account shown above)		**Secondary Authorized Signature (If Needed)**	
Printed Name	**Date**	**Printed Name**	**Date**

Insufficient Funds in the account will result in a $40.00 fee

FOR DISTRIBUTOR USE ONLY
(FTS ID - 16639)
Customer Number: _____
Date Received: _____

Fax Completed Form To:
920-336-3124 or
Mail To: P.O.Box 28375
Green Bay, WI 54324
QUESTION?call SUE
920-338-4510 or
SPOLASIK@TRIANGLEDIST.COM