Electronic Payment Program

- No Cost
- Eliminates paying with cash, checks or money orders
- Faster Deliveries
- Quick and easy sign-up
- Available for customers with 1-5 delivery locations 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:** **(always 9 digits)**
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

The undersigned on behalf of Company hereby authorizes Columbia 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 invoiceinformation. 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 accept 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 Distributor, its electronic funds service providers and Company's bank a reasonable opportunity to act on it. Company and the undersigned 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**

FOR DISTRIBUTOR USE ONLY - Circle One

(Oregon FTS ID - 14999)
(Washington FTS ID - 14998)
(Santa Rosa FTS ID - 52826)

Customer Number: _____

Date Received: _____

FAX COMPLETED FORM AND VOIDED CHECK TO: 503-240-5519

Questions? Contact Robin Penfield at 503-727-3269 or robin.penfield@coldist.com