For U.S. customers only

Direct debit enrollment form

Account name: _____

Account number (billing): _____

Contact person: _____

I (We) would like to enroll in the direct debit payment option ("Direct Debit Program"). Once I (we) enroll in the Direct Debit Program, IDEXX will electronically debit the bank account listed below on a monthly basis for any and all purchased products and service balances that are outstanding as of the end of the preceding month. I (we) understand that any payments made or credits redeemed after my (our) statement is generated may not be reflected in their entirety in my (our) direct debit calculation. Enrollment commences upon receipt of this form by IDEXX.

I (We) authorize IDEXX Laboratories, Inc. and/or its wholly owned subsidiary IDEXX Distribution, Inc. (collectively "IDEXX") to electronically debit my (our) account (and, if necessary, electronically credit my [our] account to correct erroneous debits) as follows:

Bank name: _____

Name on bank account: _____

Bank account number: _____

ACH routing number (must be exactly 9 digits): ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ Checking Account ☐ Savings Account at the financial institution named above ("Bank").
(select one; attach a copy of a voided check or deposit slip)

Remittance advice should be sent to the following:
Email address: _____

I (We) hereby authorize IDEXX to electronically debit my (our) bank account on a monthly basis on the 25th day of the month (or next business day) for any and all of the product and service balances outstanding as of the prior month's end. I (We) understand that it is my (our) responsibility to convey any changes on my (our) bank account to IDEXX Customer Service at 1-800-814-1147. In the event that the direct debit fails, I (we) understand that there will be one attempt made to contact me (us) for updated information. I (We) understand that this authorization will remain in effect until I (we) notify IDEXX in writing that I (we) wish to revoke this authorization. I (We) understand that IDEXX requires at least 1 week prior written notice in order to cancel this authorization. IDEXX cannot be held responsible for any consequential damages arising from an overdraft that may be caused as a result of the authorized debit.

Authorized representative's name (please print): _____

Authorized representative's signature: _____

Today's date: _____

Note: Enrollment is effective immediately upon receipt of this form by IDEXX.

Please scan and email completed form to **process&solutions@idexx.com** or fax to **1-888-433-9959**.