KY MEDS INC Check Draft Authorization Form

I _____(Company Name) authorize KY MEDS INC to initiate funds from the checking account indicated below. I also authorize my depository financial institution to honor these transfers.

Please Check One Box (required)

☐ This authorization is valid for this transaction only.
The transaction amount will be $_____ (transaction amount required)

☐ This is an open authorization to allow debits to my account for amounts which will vary per transaction based on the order amount.

If emailing/faxing this form, please do not mail check in.

I have read and agree to all of the terms and conditions on this page and any other contract or document that accompanies this agreement. I certify that I am the authorized account holder for this checking account. I understand this is a binding agreement and I will receive a copy of each check draft in my statement when the item has cleared.

I understand this is a legal binding agreement between KY MEDS INC and, _____ (Company Name).

I understand that all returned checks are subject to a $25.00 NSF Fee. This agreement will remain in effect until KY MEDS INC receives my written notice of cancellation via mail, fax or email.

_____ _____
Authorized Accountholder Signature (required) Date (required)

Attach Your Check Here (required)

Then Email : Accounting@kymeds.com

Or Fax to:

1-877-683-2065