STATE OF NEBRASKA ACH ENROLLMENT

MAIL TO: The University of Nebraska Medical Center Accounts Payable 985040 Ne Medical Center Omaha, Ne 68198-5040 ☐ New ☐ Change	*IF YOU HAVE ANY QUESTIONS WHEN COMPLETING THIS FORM, PLEASE CONTACT THE STATE TREASURER'S OFFICE:* State Treasurer Attn: Mary Brock ☐ CCD+ PO Box 94788 Lincoln, NE 68509 Telephone: 402-471-2455 ☒ CTX Fax: 402-471-0816

VENDOR INFORMATION	FINANCIAL INSTITUTION INFORMATION
The following information should be completed by the vendor.	*It is the Financial Institution's responsibility to assure the accuracy of the following information.*
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Federal ID Number:_____	ACH Coordinator:_____
Contact Person:_____	Phone Number:_____
Phone Number:_____	Fax Number:_____
E-Mail Address: _____	E-Mail Address: _____
Fax Number:_____	Nine-digit Routing Transit Number:_____
May this authorization be used for? (check one)	Depositor Account Title: _____
_____ All payments by the State of Nebraska _____ Only payments listed below:	Depositor Account Number:_____
	Type of Account:_____Checking _____Savings

The services below represent an agreement between the Financial Institution and the Customer relating to the Financial Institution passing the addendum information to the Customer.

1. Both parties agree that the addendum information will be provided to the customer in the following medium:

_____On-Line Query _____EDI Advice

_____No Notification Needed

2. Both parties agree that the addendum information will be provided to the customer within the following timeframe:

_____Same day as payment date _____Business day following payment date

*(Please print or type - **original** signature required)*	*(Please print or type - **original** signature required)*
Company Official Name:_____	Bank Official Name:_____
Title:_____	Title:_____
Signature:_____	Signature:_____
Date:_____	Date:_____