**STATE OF NEBRASKA ACH ENROLLMENT**

**MAIL TO:** The University of Nebraska Medical Center
Accounts Payable
985040 Ne Medical Center
Omaha, Ne 68198-5040

**IF YOU HAVE ANY QUESTIONS WHEN COMPLETING THIS FORM, PLEASE CONTACT THE STATE TREASURER'S OFFICE:**
State Treasurer
Attn: Mary Brock
PO Box 94788
Lincoln, NE 68509
Telephone: 402-471-2455
Fax: 402-471-0816

**NEW** ☐ ☐ Change

**VENDOR INFORMATION**
The following information should be completed by the vendor.

- **Name:**
- **Address:**
- **Federal ID Number:**
- **Contact Person:**
- **Phone Number:**
- **E-Mail Address:**
- **Fax Number:**
- **May this authorization be used for? (check one)**
  - All payments by the State of Nebraska
  - Only payments listed below:

**FINANCIAL INSTITUTION INFORMATION**
It is the Financial Institution's responsibility to assure the accuracy of the following information.

- **Name:**
- **Address:**
- **ACH Coordinator:**
- **Phone Number:**
- **Fax Number:**
- **E-Mail Address:**
- **Nine-digit Routing Transit Number:**
- **Depositor Account Title:**
- **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)

<table>
<thead>
<tr>
<th>Company Official Name:</th>
<th>Bank Official Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Title:</td>
</tr>
<tr>
<td>Signature:</td>
<td>Signature:</td>
</tr>
<tr>
<td>Date:</td>
<td>Date:</td>
</tr>
</tbody>
</table>