OCULAR THERAPEUTIX

Retina experience redefined

MEDICAL COLLABORATIONS

ACH Authorization

Vendor Name: _____

Tax ID: _____ (last 4 numbers only)

Remittance Email: _____

I hereby authorize and request Ocular Therapeutix, Inc. to make payment of services by initiating credit to my account in the financial institution below, hereinafter referred to as "bank." I also authorize and request the bank below to accept such credit to my account without the bank being responsible for the correctness thereof.

Bank Information

Please fill out this section in its entirety. This agreement will override any previous direct deposit agreement with Ocular Therapeutix, Inc.

Name of Bank: _____

Account Type: _____

Account #: _____

Routing #: _____

If international payment is required, please also include the following information:

IBAN #: _____

SWIFT Code: _____

Intermediary Bank: _____

Bank City, State, and Country: _____

Please feel free to include a bank letter or copy of cancelled check for reference and confirmation of the above.

_____ _____

Vendor/Contractor Signature Date

Corporate Headquarters: 15 Crosby Drive, Bedford, MA 01730 | o. 781 357 4000 | f. 781 357 4001 | www.ocutx.com