BLUE CROSS® CANASSURANCE

# Pre-authorized Debit (PAD) Agreement

## 1. PAYOR INFORMATION

Last and first names of depositors
(please print)

**FOR ADMINISTRATION ONLY**

Contract no. _____ Insured's name _____

Account holder name _____ First name _____

Joint account holder name _____ First name _____

Address _____ Street _____ Unit _____

City _____ Province _____ Postal code _____ - _____

Telephone _____ Mobile _____ E-mail _____

## 2. BANK ACCOUNT INFORMATION

**TYPE OF SERVICE: PERSONAL**

Financial institution _____

Address _____ Street _____

City _____ Province _____ Postal code _____ - _____

Institution no. __ __ __ Branch transit no. __ __ __ __ __ Account no. __ __ __ __ __ __ __ __ __ __ __ __

## 3. AUTHORIZATION OF PRE-AUTHORIZED DEBIT (PAD)

1. I, the undersigned, hereby authorize Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insurer, to debit my bank account identified above monthly, on the date indicated below or the following business day, for the sum of $_____._____, in payment of my insurance contract. If no date is entered, I understand that the date may be determined by the Insurer without giving me prior notice.

   **Desired withdrawal date:** _____ **(excluding the 29th, 30th and 31st).**

   **I have attached a sample cheque.**

   I authorize the Insurer to debit my bank account for a one-time amount when required for the payment of amounts owing in respect of my insurance policy, including service fees and applicable taxes. I understand that, for the purposes of this Agreement, all pre-authorized debits (PAD) withdrawn from my account are fixed or variable-amount personal PADs.

2. I understand that the amount of the PAD may be increased or decreased at a later date as a result of insurance policy endorsements, exclusions or renewal. I understand that the Insurer is required to send me prior notice of thirty (30) days only for the renewal of my policy.

3. I understand that if a PAD is returned due to insufficient funds, the Insurer may resubmit the PAD amount to my financial institution.

   I accept that any related service charges incurred as a result of the returned PAD will be added to the subsequent PAD.

4. I understand that I must notify the Insurer in writing of any changes to the information regarding the above-mentioned bank account at least ten (10) business days prior to a PAD.

5. I understand that I may modify the method or frequency of payment of my insurance premium by contacting the Customer Service department at **1 866 722-3444 in Ontario** or at **1 800 363-3958 in Quebec. I understand that, following a change I have requested to my insurance policy or this Agreement that changes the amount of my PAD, the Insurer is not required to notify me prior to withdrawal of the new PAD.**

6. I understand that I may revoke this authorization at any time subject to providing ten-day (10) notice in writing. To obtain a sample cancellation form or for more information on my right to cancel a PAD agreement, I may contact my financial institution or visit **www.cdnpay.ca**.

7. I understand that the Insurer may cancel this Agreement upon thirty (30) days written notice, that such cancellation will not terminate my insurance policy and that an alternative method of payment accepted by the Insurer will replace the PAD for the payment of my premiums.

8. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive a reimbursement for any PAD that is not authorized or is not consistent with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit **www.cdnpay.ca.**

## 4. SIGNATURE

_____
Signature of the account holder

Name _____
(please print)

Date _____ day/month/year

_____
Signature of joint account holder (if applicable)

Name _____
(please print)

Date _____ day/month/year

**When the form is complete, mail or fax to the Insurer, based on your province of residence:**

**Québec Blue Cross**
Administration – Personal Insurance
550 Sherbrooke Street West, Suite B-9
Montréal, Québec H3A 3S3
Fax: 1-866-286-8358

**Ontario Blue Cross**
Administration – Personal Insurance
PO Box 4434, STN A
Toronto, Ontario M5W 3Y8
Fax: 1-866-286-8358

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