



PAYMENT AUTHORIZATION FORM H1

 NEW REQUEST
 CHANGE OF EXISTING INFORMATION

INSURANCE COMPANY NAME AND POSTAL ADDRESS	POLICY NUMBER
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1. APPLICANT'S FULL NAME AND POSTAL ADDRESS	2. BROKERAGE/AGENCY INFORMATION
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CONTACT NUMBER(S) TYPE NO. TYPE NO. TYPE NO. TYPE NO.				BROKER CODE	CONTACT NAME
PREFERRED DOCUMENT LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH				PHONE NO.	FAX NO.
EMAIL ADDRESS				CONTRACT NUMBER	SUB-CONTRACT NUMBER
WEBSITE ADDRESS				GROUP / PROGRAM NAME	GROUP ID
				BROKER CLIENT ID	COMPANY CLIENT ID

3. POLICY PREMIUM DATA

TOTAL ESTIMATED POLICY PREMIUM	PROVINCIAL SALES TAX (if applicable)	INSTALLMENT FEE	% (optional)	TOTAL ESTIMATED COST

4. CONSENT AND DISCLOSURE

MY / OUR SIGNATURE CONFIRMS THAT:

- I/We have been provided with details of and understand the terms and conditions of the payment plan by automatic withdrawals from my/our financial institution account and/or my/our credit card.
- I/We hereby authorize the named financial institution below to debit my/our account for all payments payable to: _____ in payment of the insurance premiums and any applicable charges and taxes.
- I/We understand that this authorization may be cancelled by me/us upon written notice, subject to a period which shall not exceed 30 days. The payor(s) may obtain a sample cancellation form, or further information on their right to cancel a payment authorization agreement, at their financial institution or by visiting www.cdnpay.ca.
- I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/We have the right to receive reimbursement for any debit that is not authorized or is not consistent with this payment authorization agreement. To obtain more information on my/our recourse rights, I/We may contact my/our financial institution or visit www.cdnpay.ca.
- I/We warrant and guarantee that all persons whose signatures are required to sign on this account have signed this authorization below.
- If there is a change in premiums due to a change in coverage or upon renewal, the amount of the monthly withdrawal will automatically be changed.
- I/We will ensure that funds are available on each due date and understand that Non-Sufficient Funds transactions may result in one or all of the following:
 - A second presentation or attempt to withdraw funds
 - A second withdrawal notice
 - Cancellation of my/our policy
- I/We have received a copy of this authorization and have read and understand these terms and conditions.
- I/We acknowledge that this authorization concerns only pre-authorized debits in the following categories in accordance with Rule H1 of the Canadian Payments Association: pre-authorized debits.
- For pre-authorized debits, I/We shall receive, with respect to the debiting of fixed-amount payments, written notice from the Insurer, the amount to be debited and the due date(s) debiting, at least 10 calendar days prior to the date of the first payment, and such notice shall be received each time there is a change in the amount of payment.
- The account that my/our financial institution is authorized to draw upon is indicated below. A specimen cheque has been marked "void" and attached to this authorization.
- I/We undertake to inform my/our Insurer, in writing, of any change in the account information provided in this authorization prior to the next payment due date.
- I/We acknowledge that my/our Insurer is not required to verify that the pre-authorized debit was issued in accordance with the particulars of the Payor's Authorization including, but not limited to, the amount.
- I/We understand that the terms and conditions may vary between insurance companies.
- I/We understand that this authorization is continuous and will automatically apply to the renewal terms, unless instructed differently.
- I/We authorize my/our Insurer to collect or use my/our personal information for the purpose of this authorization for automatic withdrawals for payment of my/our insurance premiums. I/We authorize my/our Insurer to disclose any personal information contained in this authorization form to its financial institution to the extent disclosure is directly related to and necessary for the proper execution of the pre-authorized debit transaction for the policy number(s) noted above.
- I/We may obtain a copy of or ask questions about my/our broker's and the Insurer's personal information policies by contacting their respective privacy officers.
- I/We may withdraw my/our consent to collect, use or disclose my/our personal information for the purpose of this authorization for automatic withdrawals for payment of my/our insurance premiums. Withdrawal of my/our consent will result in cancellation of this authorization for automatic withdrawals for payment of my/our insurance premiums, in which case I/we must make other arrangements for payment of my/our insurance premiums.

5. METHOD OF PAYMENT SINGLE PAYMENT PAYMENT PLAN PLAN TYPE _____**6(A). CREDIT CARD INFORMATION - All credit cards listed below and/or credit card payment options may not be supported by the insurance company. Please refer to your broker and/or company.**

<input type="checkbox"/> AMERICAN EXPRESS	<input type="checkbox"/> DINERS CLUB	CARD NUMBER	EXPIRY DATE
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	_____	_____
<input type="checkbox"/> VISA	<input type="checkbox"/> _____	NAME AS SHOWN ON CREDIT CARD	CARDHOLDER'S SIGNATURE (if different from authorized signature below)
YOUR PREMIUM WILL BE CHARGED TO YOUR CREDIT CARD AND WILL APPEAR ON YOUR STATEMENT AS _____		<input type="checkbox"/> FOR DOWNPAYMENT ONLY	

6(B). BANK ACCOUNT INFORMATION (NAME AND POSTAL ADDRESS)

FINANCIAL INSTITUTION		ACCOUNT HOLDER	
_____		_____	
_____		POSTAL CODE	POSTAL CODE
ACCOUNT INFORMATION (Account must provide chequing privileges)		TRANSIT NUMBER	INSTITUTION NUMBER
_____		_____	_____
ACCOUNT NUMBER		_____	
ATTACH VOID CHEQUE		_____	
ACCOUNT HOLDER'S SIGNATURE (if different from authorized signature below)		ACCOUNT HOLDER'S SIGNATURE (if different from authorized signature below)	DATE
_____		_____	_____

7. PAYMENT DETAILS

DOWNPAYMENT AMOUNT \$ _____ (If applicable)	INSURANCE COMPANY ADDITIONAL CHARGES \$ _____ OR _____%	TYPE OF CHARGES _____
<input type="checkbox"/> PERSONAL <input type="checkbox"/> BUSINESS	BROKER ADDITIONAL CHARGES \$ _____ OR _____%	TYPE OF CHARGES _____
FULL PAYMENT AMOUNT \$ _____	INSTALLMENT AMOUNT (Estimated amount) \$ _____	NEXT PAYMENT DATE (PREFERRED WITHDRAWAL DATE) (If date is not applicable, payment will be defaulted to Insurer's closest standard withdrawal date)

Please note that a transaction fee may apply to any "Non-Sufficient Funds" (NSF) cheque returned.

AUTHORIZED / INSURED'S SIGNATURE	DATE
_____	_____
AUTHORIZED / INSURED'S SIGNATURE	DATE
_____	_____