Reset

PAYMENT AUTHORIZATION AND PRE-AUTHORIZED DEBIT AGREEMENT

☐ NEW REQUEST
☐ CHANGE OF EXISTING INFORMATION

INSURANCE COMPANY NAME AND POSTAL ADDRESS | POLICY NUMBER

1. APPLICANT'S FULL NAME AND POSTAL ADDRESS

POSTAL CODE

CONTACT NUMBER(S)
TYPE NO. TYPE NO.
TYPE NO. TYPE NO.

PREFERRED DOCUMENT LANGUAGE ☐ ENGLISH ☐ FRENCH

EMAIL ADDRESS

WEBSITE ADDRESS

2. BROKERAGE/AGENCY INFORMATION

POSTAL CODE

BROKER CODE | CONTACT NAME
PHONE NO. | FAX NO.
CONTRACT NUMBER | SUB-CONTRACT NUMBER
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. METHOD OF PAYMENT ☐ SINGLE PAYMENT ☐ PAYMENT PLAN PLAN TYPE _____

5(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.

☐ AMERICAN EXPRESS ☐ DINERS CLUB
☐ MASTERCARD ☐ DISCOVER
☐ VISA ☐ _____

CARD NUMBER

EXPIRY DATE YYYY MM

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 _____

☐ FOR DOWNPAYMENT ONLY

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

FINANCIAL INSTITUTION | ACCOUNT HOLDER

POSTAL CODE | POSTAL CODE

ACCOUNT INFORMATION (Account must provide chequing privileges)

ATTACH VOID CHEQUE

TRANSIT NUMBER | INSTITUTION NUMBER | ACCOUNT NUMBER

ACCOUNT HOLDER'S SIGNATURE (if different from authorized signature below) | **ACCOUNT HOLDER'S** SIGNATURE (if different from authorized signature below) | DATE YYYY/MM/DD

6. PAYMENT DETAILS

DOWNPAYMENT AMOUNT (If applicable) $ _____
INSURANCE COMPANY ADDITIONAL CHARGES $ _____ OR _____ % | TYPE OF CHARGES _____

☐ PERSONAL ☐ BUSINESS
BROKER ADDITIONAL CHARGES $ _____ OR _____ % | TYPE OF CHARGES _____

FULL PAYMENT AMOUNT $ _____
INSTALLMENT AMOUNT (Estimated amount) $ _____
NEXT PAYMENT DATE YYYY/MM/DD (PREFERRED WITHDRAWAL DATE)
(If date is not applicable, payment will be defaulted to Insurer's closest standard withdrawal date)

7. CONSENT AND DISCLOSURE

MY / OUR SIGNATURE CONFIRMS THAT:

1) 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 credit card.

2) I/We hereby authorize the named financial institution above to debit my/our account for all payments payable to: _____ in payment of the insurance premiums and any applicable charges and taxes.

3) 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. I/We may obtain a sample cancellation form, or further information on my/our right to cancel a payment authorization agreement, at my/our financial institution or by visiting www.cdnpay.ca.

4) 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.

5) I/We warrant and guarantee that all persons whose signatures are required to sign on this account have signed this authorization.

6) I/We agree that, if there is a change in premium due to a change in coverage, rate, or upon renewal, the amount of the monthly withdrawal will automatically be changed.

7) I/We will ensure that funds are available on each due date and understand that Dishonoured Funds transactions may result in one or all of the following:

1. A second presentation or attempt to withdraw funds

2. A second withdrawal notice

3. Cancellation of the policy

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INSURANCE COMPANY NAME AND POSTAL ADDRESS	POLICY NUMBER

7. CONSENT AND DISCLOSURE (continued)

8) I/We acknowledge that the rights and obligations provided in accordance with the Canadian Payments Association Rule H1 concerns only pre-authorized debits, not recurring charges to credit cards.

9) I/We agree that, for pre-authorized debits, only the insured shall receive written notice from the Insurer of the amount to be debited and the due date, at least 10 calendar days prior to the date of the first payment, and any change in the amount or date of the payment.

10) **I/We waive the right to obtain written notice from Insurer, of the amount to be debited and the due date(s) of debiting, at least 10 calendar days prior to the date of the payment, even when there is a change in the amount or payment date(s).**

11) I/We undertake to inform the Insurer, in writing, of any change in the account information provided in this authorization 10 calendar days prior to the next payment due date.

12) The account that my/our financial institution is authorized to draw upon is indicated above. A specimen cheque marked “void” or bank issued account information form is attached to this authorization.

13) I/We acknowledge that the 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.

14) I/We understand that this authorization is continuous and will automatically apply to the renewal terms, unless instructed differently.

15) I/We authorize the Insurer to collect or use my/our personal information for the purpose of this authorization for automatic withdrawals for payment of the insurance premiums. I/We authorize the 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 noted above.

16) I/We may obtain a copy of or ask questions about the broker's and the Insurer's personal information policies by contacting their respective privacy officers.

17) 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 the insurance premiums. Withdrawal of my/our consent will result in cancellation of this authorization for automatic withdrawals for payment of the insurance premiums, in which case the insured must make other arrangements for payment of the insurance premiums.

18) **I/We have received a copy of this authorization and have read and understand these terms and conditions.**

Please note that a transaction fee may apply to any "Dishonoured Funds".

AUTHORIZED SIGNATURE	DATE YYYY/MM/DD
AUTHORIZED SIGNATURE	DATE YYYY/MM/DD