

Pre-authorized Debit (PAD) Agreement

1. PAYOR INFORMATION (PLEASE PRINT)

FOR ADMINISTRATION ONLY

Last and first names of depositors

Contract no. : _____

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)

I, the undersigned, authorize Blue Cross Canassurance to debit my bank account identified above for \$_____. _____ every month on the date indicated below, in payment of my personal health insurance premium. **If no date is entered, the Insurer may determine the date without having to notify me.**

Desired date for premium with drawal: _____ day (excluding the 29, 30 and 31)

I have attached a sample cheque to this application.

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. I also understand that I may revoke this authorization at any time subject to providing notice of ten (10) days to the Insurer. 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.

4. SIGNATURE

Signature of the account holder_____
Signature of joint account holder (if applicable)Name _____
(please print)Name _____
(please print)

Date _____

Date _____

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.

When the form is complete, mail or fax to the Insurer: Blue CrossAdministration – Personal Insurance
PO Box 4434, STN A
Toronto, Ontario M5W 3Y8
Fax: 1 866 286-8358