ONTARIO BLUE CROSS®

METHOD OF PAYMENT

Contract no.

☐ **PRE-AUTHORIZED DEBIT AGREEMENT (PAD)**	Desired date for direct debit (except 29, 30 and 31) DAY

A – Payor information

Account holder		Joint account holder	
Last name	First name	Last name	First name

Company name (if the account is that of a company)

Address

No.	Street	Apt.

City	Province	Postal code

Telephone		E-mail
Home	Cell	

B – Bank account information

Financial institution

Name

Address

No.	Street

City	Province	Postal code

Bank account

Institution no.	Branch transit no.	Account no.

C – Pre-authorized debit (PAD)

1. I, the undersigned, hereby authorize Canassurance Hospital Service Association and/or Canassurance Insurance Company (CHSA and/or CIC), to debit my bank account identified above monthly, on the day indicated in the "Monthly payment information" section or the following business day, for the sum in accordance with my instructions for the periodic or one-time payment of my insurance policy.

2. I understand that the amount of the PAD may be increased or decreased at a later date as a result of insurance policy endorse- ments, exclusions or renewal. I understand that CHSA and/or CIC is required to provide me with 30 days' advance notice only for the renewal of my policy.

3. I understand that if a PAD is returned due to insufficient funds, CHSA and/or CIC 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 CHSA and/or CIC in writing of any changes to the information regarding the above-mentioned bank account at least ten 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. I understand that, following a change I have requested to my insurance policy or this Agreement that changes the amount of my PAD, CHSA and/or CIC are 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 days' 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 **payments.ca**.

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

8. I have certain recourse rights if any debit does not comply with the Agreement. For example, I have the right to receive a reimburse- ment 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 **payments.ca**.

Signature	
Account holder	Joint account holder (if applicable)
Name of the account holder (please print)	Name of the joint account holder (please print)
Date	Date

Please attach copy of void cheque

☐ **ANNUAL CHEQUE**	Please attach a cheque payable to Ontario Blue Cross.		
☐ **CREDIT CARD PAYMENT**	☐ Monthly premium $_____ ☐ Annual premium $ _____	☐ Amex ☐ Master Card ☐ VISA	
Card number			Expiry Date MM YY
Name of the cardholder (print)		Signature of the cardholder	