

For administration only

Contract no.	Insured's name
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1 – Payor information

Account holder		Joint account holder	
Last name	First name	Last name	First name
Address no.	Street	Apt.	
City		Province	Postal code
Telephone home		Telephone cellular	E-mail

2 – Bank account information
Type of service: personal

Financial institution			
Address no.	Street		
City		Province	Postal code
Bank account			
Institution no.	Branch transit no.	Account no.	

3 – Authorization of Pre-authorized debit (PAD)

- 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 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 CHSA and/or CIC without giving me prior notice.
Desired withdrawal date: _____ (excluding the 29th, 30th and 31st). I have attached a sample cheque.
I authorize CHSA and/or CIC 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 I understand that, for the purposes of this Agreement, all pre-authorized debits (PAD) withdrawn from my account are fixed or variable-amount personal PADs.
- 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 CHSA and/or CIC are required to send me prior notice of thirty (30) days only for the renewal of my policy.
- 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.
- 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 (10) business days prior to a PAD.
- 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 CHSA and/or CIC are not required to notify me prior to withdrawal of the new PAD.**
- 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 **payments.ca**.
- I understand that CHSA and/or CIC 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 CHSA and/or CIC will replace the PAD for the payment of my premiums.
- 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 **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	

When the form is complete, mail to CHSA and/or CIC based on your province of residence or send it via the document transmission form available on our website:

Québec Blue Cross, Administration – Personal Insurance, 1981 McGill College Avenue, Suite 105, Montreal, Quebec H3A 0H6, qc.bluecross.ca/depot
Ontario Blue Cross, Administration – Personal Insurance, PO Box 4434, STN A, Toronto, Ontario M5W 3Y8, on.bluecross.ca/depot