

Request for Pre-Authorized Payment Plan

Company Name _____ Firm Number _____

Contact Name (Please Print) _____
First Initial Last

Address _____

City Province Postal Code

I authorize the Chambers of Commerce Group Insurance Plan to make withdrawals for the payment of monthly premiums.

I authorize the Chambers of Commerce Group Insurance Plan to debit the account below on the 1st day of each month. **I have attached a sample cheque, marked "VOID"** to verify the necessary bank account details. The monthly debit is for group insurance premium. The amount may be variable and I will receive notice of the debit by mail approximately 3 business days before the 1st of each month. However, I will not receive notice of subsequent months' debits until such time as the amount changes.

I understand that this agreement may be revoked at any time by providing 30 days written notice. I understand that I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this agreement. I understand that I may obtain further information on my right to cancel / recourse rights by contacting my financial institution, or by visiting www.cdnpay.ca.

BANK ACCOUNT INFORMATION

Bank Name _____

Branch/Transit Number _____ Bank Number _____ Account Number _____

Branch Address _____

Authorized Signature _____ Date _____

The account you choose must have chequing privileges.