CSIO CEPA PAYMENT AUTHORIZATION FORM H1

☐ NEW REQUEST
☐ CHANGE OF EXISTING INFORMATION

INSURANCE COMPANY	LIST ALL POLICY NUMBERS APPLICABLE TO THIS PAYMENT AUTHORIZATION

1. APPLICANT'S / INSURED'S FULL NAME AND POSTAL ADDRESS

POSTAL CODE

CONTACT NUMBER ☐CELL ☐BUSINESS ☐HOME ☐FAX

CONTACT NUMBER ☐CELL ☐BUSINESS ☐HOME ☐FAX

PREFERRED LANGUAGE ☐ ENGLISH ☐ FRENCH

EMAIL ADDRESS

WEBSITE ADDRESS

2. BROKER'S NAME AND POSTAL ADDRESS

POSTAL CODE

CONTACT NUMBER ☐CELL ☐BUSINESS ☐HOME ☐FAX

CONTACT NUMBER ☐CELL ☐BUSINESS ☐HOME ☐FAX

BROKER CONTRACT NUMBER

BROKER 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. CONSENT AND DISCLOSURE

MY / OUR SIGNATURE CONFIRMS THAT:

- 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 my/our credit card.
- I/We hereby authorize the above named financial institution to debit my / our account for all payments payable to: _____ in payment of the insurance premiums and any applicable charges and taxes.
- I/We understand that this authorization may be cancelled by me / us upon written notice.
- I/We warrant and guarantee that all persons whose signatures are required to sign on this account have signed this authorization below. If there is a change in premiums due to a change in coverage or upon renewal, the amount of the monthly withdrawal will automatically be changed.
- I/We will ensure that funds are available on each due date and understand that Non-Sufficient Funds transactions may result in cancellation of my policy.
- I/We have received a copy of this authorization and have read and understand these terms and conditions.
- I/We acknowledge that this authorization concerns only pre-authorized debits in the following categories in accordance with Rule H1 of the Canadian Payments Association: Personal/household pre-authorized debits.
- For personal/household pre-authorized debits, I/We shall receive, with respect to the debiting of fixed-amount payments, written notice from the Insurer, the amount to be debited and the due date(s) of debiting, at least 10 calendar days prior to the date of the first payment, and such notice shall be received each time there is a change in the amount of payment.
- The account that my / our financial institution is authorized to draw upon is indicated below. A specimen cheque has been marked "void" and attached to this authorization.
- I/We undertake to inform my / our financial institution, in writing, of any change in the account information provided in this authorization prior to the next payment due date.
- I/We acknowledge that my / our financial institution 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.

5. METHOD OF PAYMENT ☐ SINGLE PAYMENT ☐ PAYMENT PLAN PLAN TYPE _____

6(A). CREDIT CARD INFORMATION - All credit cards listed below 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 M/M Y/Y

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 _____

DOWNPAYMENT AMOUNT $ _____	ADDITIONAL CHARGES $ _____ OR _____%	TYPE OF CHARGES _____
FULL PAYMENT AMOUNT $ _____	INSTALLMENT AMOUNT $ _____	NEXT PAYMENT DATE YYYY/MM/DD (PREFERRED WITHDRAWAL DATE)

6(B). ACCOUNT INFORMATION (NAME AND POSTAL ADDRESS)

FINANCIAL INSTITUTION	ACCOUNT HOLDER
NAME	NAME
ADDRESS	ADDRESS
POSTAL CODE	POSTAL CODE

ACCOUNT INFORMATION (Account must provide chequing privileges)

ATTACH VOID CHEQUE

TRANSIT NUMBER

INSTITUTION NUMBER

ACCOUNT NUMBER

DOWNPAYMENT AMOUNT $ _____	ADDITIONAL CHARGES $ _____ OR _____%	TYPE OF CHARGES _____
FULL PAYMENT AMOUNT $ _____	INSTALLMENT AMOUNT $ _____	NEXT PAYMENT DATE YYYY/MM/DD (PREFERRED WITHDRAWAL DATE)

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

Please note that a transaction fee will apply to any "Non-Sufficient Funds" (NSF) cheque returned.

AUTHORIZED / INSURED'S SIGNATURE	DATE YYYY/MM/DD
AUTHORIZED / INSURED'S SIGNATURE	DATE YYYY/MM/DD