



PAYMENT AUTHORIZATION FORM

INSURANCE COMPANY

POLICY NUMBER

INSURED'S FULL NAME AND POSTAL ADDRESS

BROKER'S FULL NAME AND POSTAL ADDRESS

FIRST NAME

MIDDLE NAME

LAST NAME

POSTAL CODE

POSTAL CODE

CONTACT:

PHONE _____
 FAX _____
 EMAIL _____

CONTACT:

PHONE _____
 FAX _____
 EMAIL _____

COMPANY CLIENT ID:

BROKER'S CLIENT ID:

CREDIT CARD INFORMATION

VISA
 MASTERCARD
 AMERICAN EXPRESS
 OTHER _____

CARD NUMBER

EXPIRY DATE

____/____/____
MONTH YEAR

DATE OF WITHDRAWAL

YYYY | MM | DD

AMOUNT

\$ _____

FREQUENCY

NAME AS SHOWN ON CREDIT CARD

CARDHOLDER'S SIGNATURE

FINANCIAL INSTITUTION INFORMATION

NEW

CHANGE OF INFORMATION

NAME OF ACCOUNT HOLDER (PERSON PAYING PREMIUM IF OTHER THAN INSURED)

NAME OF FINANCIAL INSTITUTION

ADDRESS

CITY

PROVINCE/TERRITORY

POSTAL CODE

ACCOUNT INFORMATION
(Account must provide chequing privileges)

TRANSIT

BANK

ACCOUNT NUMBER

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 bank account)
- 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 request.

ACCOUNT HOLDER SIGNATURE

DATE

YYYY | MM | DD

ACCOUNT HOLDER SIGNATURE

DATE

YYYY | MM | DD

If more than one signature is required on cheques issued against this account, all account holders must sign this authorization.

ATTACH VOID CHEQUE