MEDAVIE BLUE CROSS™

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT
CATEGORY: BUSINESS

Please complete this form in its entirety.

1. POLICYHOLDER INFORMATION

Legal Name of Policyholder:

Policyholder Contact Info:

Business Mailing Address		
City/Town	Province	Postal Code
Business Telephone	Business Fax	Business Email Address
Business Website Address		

Medavie Blue Cross Policy Information:
(attach sheet if necessary)

Policy Number(s)	Division Number(s)

2. ACCOUNT INFORMATION (you may skip this section if a void cheque or bank issued and stamped PAD form is attached)

Name of Financial Institution:

Contact Info:

Business Mailing Address		
City/Town	Province	Postal Code

Account Info:

Transit (Branch) #	FI (Bank) #	Account #

3. SIGNATURE OF AUTHORIZED OFFICER

I/We authorize Medavie Blue Cross, and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for recurring payments and/or one-time payments from time to time, for payment of insurance premiums. Regular monthly payments for the full amount of services delivered will be debited to my/our specified account on the first business day of every month. Medavie Blue Cross will not provide pre-notification but will provide a monthly premium statement indicating the amount of each regular debit. Medavie Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled. This notification must be sent to the Billing Department of Medavie Blue Cross. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Signature of Account Holder(s): _____

Name of Account Holder(s): _____

Date (YYYY-MM-DD): _____

Please advise Medavie Blue Cross of any future changes in banking information related to this PAD agreement.