



Contract numbers:

**1 PREMIUM PAYMENT METHOD SELECTION**

Annual  Preauthorized debit (PAD) Complete the Preauthorized Debit Agreement in section 2.

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

 \_\_\_\_\_ Name of policyholder 1 (please print)

 \_\_\_\_\_ Name of policyholder 2 (please print)

**2 PREAUTHORIZED DEBIT (PAD) AGREEMENT**


**2.1 PREMIUM PAYOR'S INFORMATION**

Policyholder 1  Policyholder 2  Other:  Mr.  Ms. \_\_\_\_\_  
 \_\_\_\_\_ First name (please print) \_\_\_\_\_ Last name (please print)

\_\_\_\_\_ Address (No., Street, Apartment, City, Province) \_\_\_\_\_ Postal code

\_\_\_\_\_ Area code \_\_\_\_\_ Telephone \_\_\_\_\_ Date of birth: \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day

**2.2 BANK ACCOUNT INFORMATION:**  Cheque specimen attached  Banking information provided below:

			_____	_____	_____
Branch number	Financial institution number	Account number	Branch number	Financial institution number	Account number

**2.3 BANK ACCOUNT TYPE:**  Personal  Business

**2.4 WITHDRAWAL DATE**

The \_\_\_\_\_ of each month (between the 1st and 30th days of the month). If a date is not indicated, it will be selected by the Insurer.

**2.5 WAIVER**

I waive my right to receive advance notice of the amount and the date of the PAD and of any change to the amount and the date.

**2.6 CANCELLATION**

This agreement may be cancelled upon receipt by the Insurer of 10 days' written notice prior to the scheduled date of the next PAD. To obtain a PAD cancellation form, or for more information about your right to cancel this agreement, contact your financial institution or visit [www.cdnipay.ca](http://www.cdnipay.ca).

**2.7 RECOURSE AND REIMBURSEMENT**

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information about your recourse rights, contact your financial institution or visit [www.cdnipay.ca](http://www.cdnipay.ca).

**2.8 AUTHORIZATION**

I authorize the Insurer or its mandatary to debit the fixed monthly amounts required for payment due to the Insurer from the account indicated on the enclosed cheque specimen or from the account identified above.

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

 \_\_\_\_\_  
 Premium payor's signature

La Capitale Insurance and Financial Services  
 625 Jacques-Parizeau St, Quebec QC G1R 2G5  
 Tel.: 418 528-2211 or 1 800 463-4433 | Email: [fmi@lacapitale.com](mailto:fmi@lacapitale.com)