You must save the file on your hard drive prior to filling the form electronically.

PAYMENT AUTHORIZATION

médicassurance

2197 Sherbrooke Street East, suite 200, Montréal (Québec) H2K 1C8
6700 Pierre-Bertrand Boulevard, suite 300, Québec (Québec) G2J 0B4
Montréal: 514 871-1181 | Québec: 418 681-7785 | Toll-Free: 1 877 371-1181
Fax | Montréal: 514 871-4943 | Toll-Free: 1 877 871-4943
info@medicassurance.ca | www.medicassurance.ca

Policy _____

PREMIUM PAYMENT METHOD

I wish to use the following means of payment:

☐ **Preauthorized bank payments:** administration fee of $2 per transaction, except for an annual payment.
Please complete the "Preauthorized Bank Payment Authorization" section. ◯ Annual ◯ Semi-annual ◯ Quarterly ◯ Bimonthly ◯ Monthly

☐ **Credit card:** administration fee of 2% of the premium.
Please complete the "Credit Card Payment Authorization" section. ◯ Annual ◯ Semi-annual ◯ Quarterly ◯ Bimonthly ◯ Monthly

☐ **Annual cheque:** Please calculate your premiums pro-rated (amount of the monthly premium x number of months covered) to reflect the annual renewal date of the policy. The period covered is indicated below. Your cheque should be made payable to MédicAssurance Inc.

PRE-AUTHORIZED PAYMENT

I hereby authorize MédicAssurance Inc. to withdraw from my account, the details of which appear on the attached specimen cheque, the sum of $ _____ on the 1st day of each month and to change the amount to be debited from my account in case of a change in the premiums for which notice has been given 30 days' prior to the date on which the change takes effect.

SIGNATURE OF ACCOUNT HOLDER(S): _____ _____
(electronic signatures are not accepted)

DATE (day / month / year): _____ TYPE OF SERVICE: ◯ Personal ◯ Business

I may revoke my authorization at any time, subject to providing notice of 30 days. To obtain a sample cancellation form, or for more information on my right to cancel a PAD (Pre-Authorized Debit) Agreement, I may contact my financial institution or visit **www.cdnpay.ca**.

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 PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit **www.cdnpay.ca**.

ATTACH A SPECIMEN CHEQUE MARKED "VOID"
Copy is accepted

CREDIT CARD PAYMENT AUTHORIZATION

I hereby authorize MédicAssurance inc. (plan administrator) to charge my credit card for the amount due according to my insurance certificate and to adjust the amount charged to my credit card should the premiums change if a 30 days notice in writing has been given prior to the adjustment. This authorization can be cancelled at any time with 30 days written notice.

◯ Visa ◯ MasterCard ◯ American Express

CARD NUMBER: _____ EXPIRATION DATE (day / month / year): _____

CARDHOLDER NAME (as indicated on the card): _____

SIGNATURE: _____ DATE (day / month / year): _____
(electronic signatures are not accepted)

THE CONSEQUENCES OF NON-PAYMENT

You are responsible for the consequences if you fail to make a payment provided in the insurance contract, i.e. when a payment is not made for any reason. At MédicAssurance inc., we know that mistakes can happen and that is why we do not charge any additional fees the first time this situation occurs. However, the second time, a fee of $45 will be charged, each time a pre-authorized payment is not honoured by your financial institution. MédicAssurance inc. will then withdraw the unpaid amount at the same time as the pre-authorized payment for the following month. Moreover, MédicAssurance inc. may terminate the pre-authorized payment method, making the annual premium then payable in full for any insurance contract the pre-authorized payment had been arranged for. A stop payment for any pre-authorized payment on the payment of your monthly premium without any prior arrangement or agreement with MédicAssurance inc. could result in cancellation of the insurance contract for which the preauthorized payment was intended.

DOCUMENT TO BE COMPLETED AND RETURNED, ACCOMPANIED BY THE APPLICATION DULY COMPLETED.