Payor's Agreement for Pre-Authorized Debits

1. I/We have attached a specimen cheque marked "VOID" to this Payor Agreement.

   I/We will inform the Payee of any change in the information provided in this Agreement. This notification must be received in writing or by phone, at least 10 days before the next debit is scheduled. Please note that any changes to the name of the Payor on the account or any change in Financial Institution must be done in writing.

2. Payee's Name and Address:

   Combined Insurance Company of America/Compagnie d'assurance Combined d'Amérique
   (herein called *Combined Insurance or Payee*)
   P.O. Box 3720 MIP, Markham, ON L3R 0X5
   Tel: 1 888 234-4466/Fax: 905-305-8600
   www.combined.ca

3. I/We may instruct the Payee, by phone or email, to change the amount of automatic withdrawal provided in this Agreement.

4. I/We understand that in the event a Pre-Authorized Debit is returned to the processing institution for the reason Non-Sufficient Funds (NSF), the returned debit will automatically be re-presented for collection from the account by the processing institution and the account may be charged for any NSF fees.

5. I/We warrant and guarantee that all persons whose signatures are required to authorize withdrawals from the account have signed this Agreement.

6. I/We hereby authorize Combined Insurance to issue Pre-Authorized Debits drawn on the account whether it continues to be maintained at the branch named, or is transferred from time to time to another branch of the bank, payable to Combined Insurance for payment of policy premiums, as required.

7. I/We may cancel this Agreement at any time subject to providing the Payee with 10 business days notice in writing or by phone. To obtain a sample cancellation form or for information on my/our right to cancel this Agreement, I/we may contact my/our financial institution or visit www.cdnpay.ca.

8. I/We acknowledge that the processing institution is not required to verify that a Pre-Authorized Debit has been issued in accordance with the particulars of this Agreement including, but not limited to, the amount, or that any purpose of payment for which the Pre-Authorized Debit was issued has been fulfilled by the Payee as a condition to honouring a Pre-Authorized Debit issued or caused to be issued by the Payee on the account.

9. Revocation of this Agreement does not terminate any contract for goods or services that exists between me/us and the Payee. This Agreement applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.

10. 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 debit that is not authorized or is not consistent with this Pre-Authorized Debit Agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

11. I/We waive the right to receive 10 days' notice of an increase or decrease in the amount of automatic withdrawal or a change in the date of the withdrawal.

COMBINED INSURANCE COMPANY OF AMERICA
COMPAGNIE D'ASSURANCE COMBINED D'AMÉRIQUE

300

PERSONAL PRE-AUTHORIZED DEBIT AGREEMENT

300

DEPOSITOR NAME(S) ON BANK OR FINANCIAL INSTITUTION RECORDS

POLICY TYPE (A = ACCIDENT, H = HEALTH, L = LIFE)

POLICY NUMBER

PRINT POLICYHOLDER NAME

TODAY'S DATE MM DD YY

FIXED MONTHLY PREMIUM FOR THE POLICY(IES) $

1. The withdrawals shall be made on or about:
   a) The Preferred Billing Day(s) of Month if indicated on policy application form(s) or;
   b) The premium due date or dates of the policy or policies.
2. This Pre-Authorized Debit Agreement shall not be construed as a modification of the policy or policies, except that during the continuance of this Agreement, the Company shall not be required to give notice of premiums becoming due on the policy or policies.
3. If any listed policy contains an automatic premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit Schedule.

BANK NAME

BRANCH ADDRESS

CITY AND PROVINCE

BRANCH NUMBER BANK NUMBER CUSTOMER ACCOUNT NUMBER

DEPOSITOR SIGNATURE AS ON FILE AT BANK OR FINANCIAL INSTITUTION

PRINT SALES REPRESENTATIVE'S NAME CODE #

USE THIS SECTION ONLY TO CHANGE INFORMATION ON FILE

CHANGE BANK INFORMATION ON FILE ☐

CHANGE PREFERRED BILLING DAY OF MONTH (1 TO 28 ONLY)

ADHESIVE STRIP · ADHESIVE STRIP · ADHESIVE STRIP · ADHESIVE STRIP

ATTACH VOID CHEQUE HERE
BANK ACCOUNT MUST HAVE CHEQUING PRIVILEGES

ADHESIVE STRIP · ADHESIVE STRIP · ADHESIVE STRIP · ADHESIVE STRIP

ALIGN BOTTOM LEFT CORNER OF VOID CHEQUE HERE

Office Copy