



**AUTHORIZATION FOR PRE-AUTHORIZED DEBITS ("PADS") AND CREDIT CARD DEBITS**

I/we authorize Howick Mutual Insurance Company 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 regular recurring payments and/or one-time payments from time to time, for payment of insurance premium. Regular payments for the full amount of premium plus taxes will be debited to my/our specified account on the selected day of each month. Howick Mutual Insurance Company will provide 10 days written notice of the amount of each regular debit. Howick Mutual Insurance Company will obtain my/our authorization for any other one-time or sporadic debits. All amounts debited will be in Canadian funds.

This authority is to remain in effect until Howick Mutual Insurance Company has received written notification from me/us of its change or termination. This notification must be received at least 10 business days before the next debit is scheduled at the address provided herein. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a Payment Authorization Agreement at my/our financial institution or by visiting [www.cdnpay.ca](http://www.cdnpay.ca). Howick Mutual Insurance Company may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us.

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 automatic debit that is not authorized or is not consistent with this Payment Authorization Agreement. To obtain a form for Reimbursement Claim or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

A fee will be charged to any "NSF" returns.

**1. Policyholder(s) Name and Address (please print)**

Name	Home Telephone #	Business Telephone #
Mailing Address	City/Town	Province & Postal Code
Type of Policy	Insurance Policy #	
Personal      Business		

**2. Withdrawal Date**

Please choose preferred date by checking the appropriate box.

1st      8th      16th      24th

**3. Payment Interval**

Monthly      Quarterly  
Semi-Annual      Annual (*Credit Card only*)

**4. Pre-authorized Debit (please print)**

Name of Financial Institution		
Bank Branch Transit # (5 digits)	Institution # (3 digits)	CDN Bank Account #

**5. Pre-authorized Credit Card (please print)**

<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	
Credit Card Number	Expiration Date (MM/YY)
Cardholder Name (please print)	Cardholder Signature

Date: \_\_\_\_\_

Authorized Signature(s): \_\_\_\_\_

Authorized Signature(s): \_\_\_\_\_