



**PAYMENT AUTHORIZATION AND
PRE AUTHORIZED DEBIT AGREEMENT FORM**

Insurance Company Information

Echelon Insurance
2680 Matheson Blvd. East, Suite 300
Mississauga, ON L4W 0A5
Toll-Free: 1-800-324-3566 Fax: 905-214-7883

Brokerage or Agency Information

Company name _____
Street address _____
City _____ Province ____ Postal ____
Phone number _____

Policy Holder Information

Policy number _____
Policyholder name _____
Street address _____
City _____ Province ____ Postal ____

PAYMENT OPTIONS (Check One)

- 1 Full payment
2 Full payment by EFT
3 Full payment by credit card
- 4 Monthly Payment Plan by EFT
5 Monthly Payment Plan by credit card
Preferred withdraw date (1 to 28th) (mm/dd/yyyy)
- New Request Start date: (mm/dd/yyyy)
 Change of existing information

NOTE: For all options except 1, all future payments will automatically be charged to credit card or debited directly from insured's account (i.e. renewal/ policy changes).

CREDIT CARD INFORMATION

CREDIT CARD NUMBER				EXPIRY DATE		PAYMENT AMOUNT		INITIAL	
NAME AS SHOWN ON CREDIT CARD				Card Type CARD TYPE		CARDHOLDER'S SIGNATURE			

I understand a \$50 service fee will be applied if the credit card is not authorized for the amount stated above, credit card information is incorrect, and/or invalid expiry date is provided.

DIRECT DEBIT INFORMATION (PLEASE ATTACH A VOID CHEQUE)

Account must provide chequing privileges

TRANSIT	BANK	ACCOUNT NUMBER	ACCOUNT HOLDER NAME(S)	
NAME OF FINANCIAL INSTITUTION			(if different from authorized signature below) ACCOUNT HOLDER SIGNATURE(S)	
Street address	City	Province	Postal	(if different from authorized signature below) ACCOUNT HOLDER SIGNATURE(S)
ADDRESS OF FINANCIAL INSTITUTION				

CONSENT AND DISCLOSURE

1. I/We have been provided with details and understand the terms and conditions of the payment plan by automatic withdrawals from my/our bank account or credit card.
2. I/We hereby authorize the financial institution listed above to debit my/our account or credit card for all payments payable to Echelon Insurance ("Echelon") in payment of insurance premiums, and any applicable charges and taxes.
3. I/We understand my/our account or credit card listed above will be debited for all recurring monthly payments and any one-time payment(s) as required by Echelon. A monthly payment schedule will be provided at least **10 days** before the first monthly withdrawal. The payment schedule will include the dates and the amount of the withdrawals.
4. I/We understand that this authorization is continuous and will automatically apply to the renewal terms, unless otherwise instructed differently.
5. I/We agree that if there is a change in premium due to a change in coverage, rate, or upon renewal, the amount of my/our monthly withdrawal will automatically be changed.
6. I/We understand that this authorization may be cancelled by me/us by giving Echelon written notice of cancellation at least 15 days before the next scheduled withdrawal. A sample cancellation form or further information on my/our right to cancel this agreement can be obtained at the financial institution or by visiting www.cdnipay.ca. Any notice to Echelon can be sent to the address indicated above.
7. I/We agree to inform the Echelon, in writing, of any change in the account /credit card information provided in this authorization 10 calendar days prior to the next scheduled withdrawal.
8. I/We understand that in the following circumstances a **\$50 service fee** will be applied if:
 - Funds are insufficient or if the account is not authorized for a withdrawal of the scheduled amount
 - The account is frozen or closed
 - The account information is incorrect or payment authorization is stopped without the required notice.
9. Except as set out above, I/we agree to waive any requirement that Echelon provide me/us with notification of any withdrawals from my/our account in advance of the withdrawal.

Authorized signature _____ Date _____
Authorized signature _____ Date _____

These services are for (please check one)
 Personal Business

I/We acknowledge and confirm that we are aware that I/we have certain recourse if any debit does not comply with these terms. For example, I/we understand that I/we have the right to receive a reimbursement for any Pre-Authorized Debit that is not authorized or is not consistent with this Agreement. I am/We are aware that I/we can obtain more information regarding my/our rights by visiting www.cdnipay.ca or by contacting my/our financial institution or credit card provider.