

PAYMENT AUTHORIZATION

Association québécoise des informaticiennes
et informaticiens indépendants

Policy 95904 - Period from March 1st, 2011 to February 29th, 2012



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info@medicassurance.ca www.medicassurance.ca

PREMIUM PAYMENT METHOD

Check one box only:

- Monthly Pre-authorized payment:** monthly administration fee of \$1 will be applied to the monthly premium.
In order to choose this type of payment, please fill in the section: "Pre-authorized payment"
- Payment by credit card:** administration fee of \$1 per transaction will be applied. In order to choose this type of payment, please fill in the section "Credit Card Payment Authorization" Annual Half-yearly Quarterly Bimonthly Monthly
- Annual payment by check:**
Please calculate your premium in prorata according to the annual renewal date of members. The annual renewal date is March 1st of each year to February 29th of the next year. The check must be 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) : _____

Date : _____ 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 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"

(A copy is accepted)

CREDIT CARD PAYMENT AUTHORIZATION

I authorize, MédicAssurance inc.; to charge my credit card for the amount due according to my insurance certificate; 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 day's written notice.

Visa Master Card Amex

CARD NUMBER: _____ EXPIRATION DATE: _____

NAME AS INDICATED ON THE CREDIT CARD: _____

SIGNATURE: _____ DATE: _____

THE CONSEQUENCES OF NON-PAYMENT

You are solely responsible for the consequences of a non-payment and any obligations that it may give rise to under the terms and conditions of the policy contract.

You are in default of payment when a pre-authorized payment is not honoured because of non-sufficient funds, closed account or other similar reasons.

If your financial institution does not honour a debit because of non-sufficient funds, MédicAssurance Inc. will debit that amount again with the next monthly debit along with a fee of \$25 after the third return not honoured. MédicAssurance Inc. may also terminate this agreement and the annual premium would then be due for all policies covered by this Agreement.

A notice of "Stop Payment" initiated by you without prior agreement with MédicAssurance Inc. for the payment of the premium, will result in the cancellation of all policies covered by this Agreement.

DOCUMENT TO COMPLETE AND RETURN, ACCOMPANIED
BY THE DULY COMPLETED APPLICATION.