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PAYMENT AUTHORIZATION FORM

POLICY NUMBER _____ AGENT/BROKER NUMBER _____

INSURED'S FULL NAME AND POSTAL ADDRESS _____

 _____ POSTAL CODE _____

CONTACT NUMBERS: HOME _____ BUSINESS _____

EMAIL ADDRESS _____

THIS IS AN INSURANCE POLICY RELATED TO THE PAYOR'S (CHECK ONE)

PERSONAL PROPERTY AND/OR AUTOMOBILE _____
 BUSINESS PROPERTY AND/OR AUTOMOBILE _____

PLEASE COMPLETE SECTION 1 OR 2.

___ NEW INFORMATION ___ CHANGE INFORMATION

SECTION 1 - CREDIT CARD INFORMATION

NAME AS SHOWN ON CREDIT CARD _____

___ MASTERCARD CARD NUMBER - - - - - - - - - - - - - - - - - - - -

___ VISA EXPIRY DATE ___ MM ___ YY

FREQUENCY ___ ANNUAL ___ MONTHLY DATE OF PAYMENT 7TH 21ST (Please check one)

CARDHOLDER'S SIGNATURE _____ DATE _____

SECTION 2 - FINANCIAL INSTITUTION INFORMATION

NAME AS SHOWN ON ACCOUNT _____

NAME OF FINANCIAL INSTITUTION _____

ACCOUNT INFORMATION TRANSIT NUMBER _____ INSTITUTE NUMBER _____ ACCOUNT NUMBER _____

DATE OF WITHDRAWAL 7TH 21ST (Please check one) **ATTACH VOID CHEQUE OR BANK CONFIRMATION**

ACCOUNT HOLDER SIGNATURE _____ DATE _____

ACCOUNT HOLDER SIGNATURE _____ DATE _____

IF MORE THAN ONE SIGNATURE IS REQUIRED ON CHEQUES ISSUED AGAINST THIS ACCOUNT, ALL ACCOUNT HOLDERS MUST SIGN AUTHORIZATION.

IT IS RECOMMENDED THAT OVERDRAFT PROTECTION BE OBTAINED TO PREVENT FAILURE OF PAYMENT DUE TO NON-SUFFICIENT FUNDS. PAYMENTS RETURNED WILL BE AUTOMATICALLY RESUBMITTED WHICH MAY RESULT IN MULTIPLE SERVICE FEES CHARGED BY YOUR FINANCIAL INSTITUTION.

PAYMENT AUTHORIZATION FORM

CONSENT AND DISCLOSURE

MY / OUR SIGNATURES ABOVE CONFIRMS THAT:

- I / We have provided personal information in this document and otherwise and I / we may in the future provide further personal information. Some of this personal information may include, but is not limited to, my/our credit and financial information. I / We authorize my/our broker and insurance company to collect, use and disclose any of this personal information subject to law and to my broker's or insurance company's policy regarding personal information, for the purposes necessary to deduct insurance payments from my/our account at the financial institution named above.
- Any change in bank account or credit card information must be submitted to either the company directly, or taken to your broker, at least two weeks prior to the next scheduled payment.
- I / We understand that a 3% Service Charge will be applied to the monthly policy premiums.
- I / We understand that any refunds will be refunded back to the policyholder(s) in the form of a cheque.
- I / We authorize Trillium 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 monthly regular recurring payments and / or one-time payments from time to time, for payment of insurance premium. Regular monthly payments for the full amount of premium plus taxes and service charges will be debited to my / our specified account on the specified day of the month.
- These amounts may vary depending on policy changes or renewals. Trillium Mutual Insurance Company agrees to provide at least 10 days written notice of the amount of each regular debit or payment change.
- Trillium 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 Trillium Mutual Insurance Company has received written notification from me / us of its change or termination. The notification must be received at least 10 business days before the next debit is scheduled at the address provided above. I / We may obtain a sample cancellation form, or more information on my / our right to cancel at PAD Agreement at my / our financial institution or by visiting www.cdnpay.ca
- Trillium 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 PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim or for more information on my / our recourse rights, I / we may contact my / our financial institution or visit www.cdnpay.ca.

I / We have been provided with details of and understand the terms and conditions of the payment plan selected above and agree to abide as outlined.

Authorized Signature(s) _____

Date: _____