Pre-Authorized Debit Agreement for One-Time Trust Deposit

FlexSave™

Customer Information

Name: _____

Address: _____

City: _____ Province: _____

Phone Number: _____ Postal Code: _____

Amount of Debit: $ _____

Bank Account Information

Please attach a VOID cheque

Account Number															
Branch Transit Number															
Financial Institution Number															
Financial Institution Name															
Branch Address															

Pre-Authorized Debit Details

These services are for (check one) ☐ Business ☐ Personal

I/we authorize HUB Financial Inc., and the financial institution designated (or any other financial institution I/We may authorize at any time) to deduct as per my/our instructions for a one-time payment to fund the Private Health Spending Plan.

This authority is for a one-time payment only and any other withdrawals require additional authorization.

HUB Financial reserves the right to assess a charge for handling of a dishonored PAD.

Signatures

Signature of Account Holder: X _____

Name of Account Holder: _____

Signature of Joint Account Holder (if applicable): X _____

Name of Joint Account Holder (if applicable): _____

Date: _____
DD/MMM/YYYY

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 of any debit that is not authorized or is not consistent with this PAD Agreement To obtain more information on your recourse rights, contact your financial institution or visit **www.cdnpay.ca**.

HUB

When this form is complete, please e-mail it to: flexsave@hubfinancial.com.