Pre-Authorized Debit Agreement for Monthly Trust Deposit

HUB | FlexSave™

CUSTOMER INFORMATION

Name: _____

Address: _____

City: _____ Province: _____

Phone Number: _____ Postal Code: _____

Amount of Debit: $ _____

BANK ACCOUNT INFORMATION

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 begin deductions as per my/our instructions for monthly regular recurring payments to pay premium due for Stop Loss / Travel Medical Insurance premiums on or about the 15th day of each month.

This authority is to remain in effect until HUB Financial Inc. has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below.

I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting **www.cdnpay.ca**.

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**.