Catastrophic (Stop Loss) / Travel Medical Plan Enrollment

FlexSave™

Employee Information

Company Name: _____

Employee Name: _____

Select One:

☐ Company Contribution ☐ Employee Contribution

Payment Mode:

☐ Annually ☐ Monthly

Coverage Details

STOP LOSS ENROLLMENT IS OPTIONAL (Maximum Coverage Age is under 70)
Please indicate plan requested.

	Plan Type	Annual Premium	Monthly Premium
☐	Single	$110.00	$9.17
☐	Couple	$210.00	$17.50
☐	Family	$270.00	$22.50

Effective Date of Coverage: (all coverage begins on the 1st of the month selected) _____
MMM /YYYY

Premium rates are provided for information only. Premium will be paid in accordance with plan setup.

Pre-Authorized Debit Details / Bank Account Information

Please attach a VOID cheque

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

Banking Information Already Provided: ☐

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.

Account Number: | | | | | | | | | | | | | | |

Branch Transit Number: | | | | | |

Financial Institution Number: | | | |

Financial Institution Name: _____

Branch Address: _____

_____

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

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