CPA INSURANCE PLANS WEST

Pre-authorized Debit

Name	
Address	
Certificate number	Postal code
Telephone numbers (Area code + no.)	Email

Account number	Branch transit number
Financial institute number	

I/we authorize CPA Insurance Plans West to debit the bank account identified above for my monthly insurance premiums the 20th of every month or the next business day. I acknowledge that a $1.00 monthly service charge will be included.

These services are for: ☐ Personal ☐ Business Use

I/we may revoke our authorization at any time subject to providing written notice 10 days prior to the payment date. To obtain a sample cancellation form or for more information on your right to cancel a PAD Agreement, contact your financial institution or visit www.cdnpay.ca.

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

_____ _____

Signature of Account Holder Date

_____ _____

Signature of Joint Account Holder Date

PLEASE EMAIL (INFO@CPAIPW.CA) OR SEND THE ORIGINAL TO CPA INSURANCE PLANS WEST AND KEEP A COPY FOR YOUR FILE.
COPY OF VOID CHEQUE MUST ACCOMPANY THIS FORM.