PAYMENT AUTHORIZATION FORM H1

☐ NEW REQUEST
☐ CHANGE OF EXISTING INFORMATION

INSURANCE COMPANY	LIST ALL POLICY NUMBERS APPLICABLE TO THIS PAYMENT AUTHORIZATION

1. APPLICANT'S / INSURED'S FULL NAME AND POSTAL ADDRESS

POSTAL CODE

CONTACT NUMBER
HOME — CELL
BUSINESS — FAX

PREFERRED LANGUAGE ☑ ENGLISH ☐ FRENCH

EMAIL ADDRESS

WEBSITE ADDRESS

2. BROKER'S NAME AND POSTAL ADDRESS

Axion Insurance Services Inc.
95 Mural Street, Suite 205
Richmond Hill, Ontario
POSTAL CODE L4B 3G2

CONTACT NUMBER
HOME — CELL
BUSINESS — FAX

BROKER CONTRACT NUMBER	BROKER SUB-CONTRACT NUMBER
GROUP / PROGRAM NAME	GROUP ID
BROKER CLIENT ID	COMPANY CLIENT ID

3. POLICY PREMIUM DATA

TOTAL ESTIMATED POLICY PREMIUM	PROVINCIAL SALES TAX (if applicable)	INSTALLMENT FEE	% (optional)	TOTAL ESTIMATED COST

4. CONSENT AND DISCLOSURE

MY / OUR SIGNATURE CONFIRMS THAT:

- I/We have been provided with details of and understand the terms and conditions of the payment plan by automatic withdrawals from my/our financial institution account and/or my/our credit card
- I/We hereby authorize the named financial institution below to debit my/our account for all payments payable to: ______________ in payment of the insurance premiums and any applicable charges and taxes.
- I/We understand that this authorization may be cancelled by me/us upon written notice.
- I/We warrant and guarantee that all persons whose signatures are required to sign on this account have signed this authorization below.
- If there is a change in premiums due to a change in coverage or upon renewal, the amount of the monthly withdrawal will automatically be changed.
- I/We will ensure that funds are available on each due date and understand that Non-Sufficient Funds transactions may result in one or all of the following:
  1. A second presentation or attempt to withdraw funds 2. A second withdrawal notice 3. Cancellation of my/our policy
- I/We have received a copy of this authorization and have read and understand these terms and conditions.
- I/We acknowledge that this authorization concerns only pre-authorized debits in the following categories in accordance with Rule H1 of the Canadian Payments Association: pre-authorized debits.
- For pre-authorized debits, I/We shall receive, with respect to the debiting of fixed-amount payments, written notice from the Insurer, the amount to be debited and the due date(s) of debiting, at least 10 calendar days prior to the date of the first payment, and such notice shall be received each time there is a change in the amount of payment.
- The account that my/our financial institution is authorized to draw upon is indicated below. A specimen cheque has been marked "void" and attached to this authorization.
- I/We undertake to inform my/our insurance company, in writing, of any change in the account information provided in this authorization prior to the next payment due date.
- I/We acknowledge that my/our insurance company is not required to verify that the pre-authorized debit was issued in accordance with the particulars of the Payor's Authorization including, but not limited to, the amount.
- I/We understand that the terms and conditions may vary between insurance companies.
- I/We understand that this authorization is continuous and will automatically apply to the renewal terms, unless instructed differently.
- I/We consent to my/our insurance company's disclosure to their financial institution of any personal information that may be contained in this authorization form, as far as any such disclosure of personal information is directly related to and necessary for the proper execution of the pre-authorized debit transaction for the policy number(s) noted above.

5. METHOD OF PAYMENT ☐ SINGLE PAYMENT ☐ PAYMENT PLAN PLAN TYPE ______________

6(A). CREDIT CARD INFORMATION - All credit cards listed below and/or credit card payment options may not be supported by the insurance company. Please refer to your broker and/or company.

☐ AMERICAN EXPRESS ☐ DINERS CLUB
☐ MASTERCARD ☐ DISCOVER
☐ VISA ☐ ______________

CARD NUMBER | EXPIRY DATE

NAME AS SHOWN ON CREDIT CARD

CARDHOLDER'S SIGNATURE (if different from authorized signature below)

YOUR PREMIUM WILL BE CHARGED TO YOUR CREDIT CARD AND WILL APPEAR ON YOUR STATEMENT AS ______________

DOWNPAYMENT AMOUNT $ (If applicable)	ADDITIONAL CHARGES $ ____ OR ____ %	TYPE OF CHARGES
FULL PAYMENT AMOUNT $	INSTALLMENT AMOUNT (Estimated amount) $	NEXT PAYMENT DATE (PREFERRED WITHDRAWAL DATE) (If date is not applicable, payment will be defaulted to Insurer's closest standard withdrawal date)

6(B). ACCOUNT INFORMATION (NAME AND POSTAL ADDRESS)

FINANCIAL INSTITUTION	ACCOUNT HOLDER
POSTAL CODE	POSTAL CODE

ACCOUNT INFORMATION (Account must provide chequing privileges)

TRANSIT NUMBER | INSTITUTION NUMBER | ACCOUNT NUMBER

ATTACH VOID CHEQUE

DOWNPAYMENT AMOUNT $ (If applicable)	ADDITIONAL CHARGES $ ____ OR ____ %	TYPE OF CHARGES
FULL PAYMENT AMOUNT $	INSTALLMENT AMOUNT (Estimated amount) $	NEXT PAYMENT DATE (PREFERRED WITHDRAWAL DATE) (If date is not applicable, payment will be defaulted to Insurer's closest standard withdrawal date)

ACCOUNT HOLDER'S SIGNATURE (if different from authorized signature below)	**ACCOUNT HOLDER'S SIGNATURE** (if different from authorized signature below)	DATE

Please note that a transaction fee may apply to any "Non-Sufficient Funds" (NSF) cheque returned.

AUTHORIZED / INSURED'S SIGNATURE	DATE
AUTHORIZED / INSURED'S SIGNATURE	DATE

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