PRE-AUTHORIZED DEBIT (PAD) Agreement

Please complete this PAD Agreement and return it to: Administration at Group Medical Services, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3. The original signed form is required for pre-authorized debits to be authorized.

A. General Information

GMS ID No. *(if applicable)*	Group Plan No. *(if applicable)*	Date *(DD/MM/YYYY)*

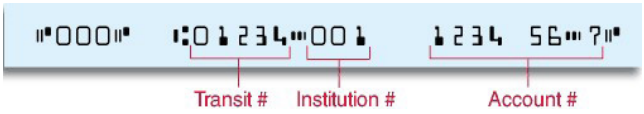
First Name	Last Name	Date of Birth *(DD/MM/YYYY)*

B. Account Information

Financial Institution Name	Address	

City	Province	Postal Code

Please include a void cheque with this agreement or use one to provide the Transit, Institution and Account numbers below.



Branch Transit Number	Institution Number	Account Number

Type of Account *(only Canadian accounts are acceptable)*	I request regular monthly payments for the full amount of services delivered to be debited from my account on the	I want to use this same account for claim payments for myself and family members covered under the plan.
❑ Savings ❑ Chequing	❑ 1st or ❑ 15th *(only choose one date)*.	❑ Yes ❑ No *(if not, please contact us to set up account)*

C. Declaration

I/We ("I") authorize Group Medical Services (GMS), and the financial institution designated to begin deductions as per my/our ("my") instructions for monthly regular recurring payments and/or one-time payments following notification by written notice, for all charges arising under my GMS account(s).

I waive my right to receive pre-notification of the amount of the PAD and agree that I do not require advance notice of the amount of PADs before the debit is processed.

This PAD Agreement may be cancelled at any time provided notice is received, in writing, at the address provided above at least 10 business days before the next debit is scheduled to be processed. Please contact our office or visit our website to obtain a cancellation form.

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

Signature of Authorized Account Holder*	Signature of Authorized Account Holder*
X	**X**
Name *(please print)*	Name *(please print)*

**Where Account Holder's account agreement requires the signature of two or more signing authorities, the signatures of all such persons are required for the purposes of this Pre-Authorized Debit Agreement.*

Please remember the following when using Pre-Authorized Debit:

- You may be subject to an administration charge for each monthly withdrawal.
- Non-Sufficient Funds (NSF) withdrawals will be handled in accordance with GMS' standard NSF policy and in accordance with the rules laid out by The Canadian Payments Association (CPA).
- Information on the administration charge and GMS' standard NSF policy can be found on gms.ca.
- Withdrawal payments will continue until such time as written notice to the contrary is given, in accordance to the right of termination of this PAD Agreement.
- Any change to the information provided under this PAD Agreement or to the product or service for which this PAD Agreement is attached will require that a new PAD Agreement be completed, signed and submitted to GMS Head Office along with a void cheque. We require receipt of this new PAD Agreement at least 10 business days before the next debit is scheduled to be processed.