

SVMA Group Health Plan

Health insurance and benefits for our members, clinic staff and families at better 'pooled' rates.



PRE-AUTHORIZED DEBIT AGREEMENT

1. MEMBER INFORMATION (please print)

Name _____

SVMA License # _____ Email Address _____

2. BANK ACCOUNT INFORMATION



Account Number

Branch Transit Number

Financial Institution Number

Financial Institution Name & Branch Address _____

3. CONSENT & AGREEMENT

- By submitting this form, I authorize the Saskatchewan Veterinary Medical Association (SVMA) to debit the bank account identified above in the amount of \$_____ on the first business day of every month, as payment for my SVMA Group Health Plan policy. If funds are not available on this date, the debit will be represented three (3) days later. I authorize SVMA to present multiple payments as required to maintain my policy and/or to charge a service fee for declined debits. I agree that SVMA is not responsible for any bank service charges relating to declined debits.
- I may revoke my authorization at any time by submitting written notice to SVMA at least ten (10) business days before the next debit date.
- I have certain recourse rights if any debit presented by SVMA 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. For further information about PAD agreements (rights, cancellation forms, etc) I can contact my financial institution or visit www.cdnpay.ca.

Signature of Account Holder

Name (please print)

Date

Signature of Joint Account Holder (if applicable)

Name (please print)

Date

4. Submit this completed form to the SVMA office by any of the following methods:

- > By regular mail to the Saskatchewan Veterinary Medical Association, 224 Pacific Ave, Suite 202, Saskatoon SK S7K 1N9
- > By email to svma@svma.sk.ca
- > By fax to 306-975-0623