



PRE-AUTHORIZED DEBIT ("PAD") AGREEMENT

Name(s) of Applicant(s): _____ IPS Contract No. _____

Authorization

You, the Account Owner(s), authorize Insurance Premium Solutions Corp (the "Company") and the financial institution named below, to withdraw the total monthly cost, including sales tax if applicable, in the sum of \$_____ from the account identified below. Payments will be debited from your account on the _____ (5th or 20th) day of each month. Please specify your preferred day. If no day is specified, payments will be debited on the above day closest to the policy date.

You waive the right to receive pre-notification of

- the amount and date of the first PAD; and
• an increase in the amount of the monthly debit due to an increase in any applicable sales tax.

If a PAD is dishonoured, you authorize the Company to add the amount of your dishonoured PAD, together with any applicable dishonoured administration fee, to your next PAD and you waive the right to receive pre-notification of such increase to the next debited payment.

The Company is not required to provide you with written notice of a change in amount that is made as a result of your request.

Banking Information for Monthly Pre-Authorized Debits
Please attach a personalized "VOID" cheque or provide the information below:
Name of Financial Institution ("FI"):
Branch Address:
FI No.: (3 digits) _____ Branch Transit No.: (5 digits) _____ Account Number: _____
Name(s) of Account Owner(s) as shown on FI records: _____
Name(s) of Account Owner(s) as shown on FI records: _____
Address of Account Owner(s): _____
You agree to notify the Company, in writing, of any change to your banking information.

PAD Category

[] Personal Expense [] Business Expense (If this is not filled in, the PAD will be treated as personal.)

Cancellation

You may cancel this authorization by providing the Company with thirty (30) days' notice. 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. Cancellation of this PAD Agreement could have an effect on the warranty, unless the payment is received when due and is made in accordance with the terms of the IPS Contract. This PAD Agreement only applies to the method of payment.

Recourse

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 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.

Contact Information

Insurance Premium Solutions- 4365-99 St. Edmonton AB. T6E 5E4 PH. 780-988-1111 FAX. 780-989-0770

You acknowledge that you have received a copy of this PAD Agreement.

Where your bank account requires the signature of two or more signing authorities, all such persons are required to sign below. Where the account is in the name of an organization (such as a company), this PAD Agreement must be signed by an authorized signatory.

X
Signature of Account Holder Date mm/dd/yr

X
Signature (s) of all other Account Owners (if needed) Date: mm/dd/yr