

Please submit this PAD Cancellation Notice to: Administration at Group Medical Services, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3.

A. General Information

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

Please indicate what type of use this Cancellation Notice is for:

Business (I am an employer cancelling my Pre-Authorized Debit Agreement.)

Employer Name

Personal (I am an individual cancelling my Pre-Authorized Debit Agreement.)

First Name	Last Name
------------	-----------

C. Declaration

First Name	Last Name
------------	-----------

I/We ("I") _____,

cancel my/our ("my") authorization to issue Personal Pre-Authorized Debits in the amount of \$ _____ against my financial institution account number _____ effective (DD/MM/YYYY) _____.

I acknowledge that this cancellation of the PAD Agreement does not terminate any other obligation that I may have with GMS, under any broader contract for services and am bound to fulfill my obligations under my contract with GMS. I understand that I am still responsible for remitting premiums to GMS, and upon cancellation of this authorization will ensure that any unpaid premiums are remitted in full immediately.

Signature of Authorized Account Holder* X	Signature of Authorized Account Holder* 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 Cancellation Notice.

Note: Subject to the terms of any agreement between the Policyholder and GMS including their PAD Agreement, a completed Cancellation Notice may be provided to GMS by way of mail, registered mail, email, fax or pre-paid courier and must be provided in compliance with the notice requirements for cancellations, if any, set out in the applicable PAD Agreement.