



Please complete all sections and return with a void cheque (if not already provided) to GMS Head Office: #200 – 3303 Hillsdale Street, Regina, SK S4S 7J8. The original signed form is required for pre-authorized payment to be authorized.

A. Personal Information

Name of Contract Holder _____ GMS ID No. _____
Name(s) of Bank Account Holder _____ Email _____
Address _____ City _____ Province _____ Postal Code _____
Phone () _____ Fax () _____

B. Account Information

Type of Account:
[] Chequing If the account being used is a chequing account, please provide a blank cheque marked "Void."
[] Savings If the account being used is a savings account, please provide the following information:

Name of Bank/Financial Institution _____
Bank Number (3 digits) _____ Transit Number (5 digits) _____ Account Number _____
Address _____ City/Town _____ Province _____ Postal Code _____

- Please remember the following when using Pre-Authorized Payments:
• Payment for the first month's premium amount must be included with this application.
• A \$1 administration charge will be applied to each monthly withdrawal.
• NSF withdrawals will be handled in accordance with GMS standard NSF policy
• Withdrawal payments will continue until such time as written notice to the contrary is given.
• We require 30 days notice, in writing, if there is a change to your banking information.

C. Declaration

I/We ("I") hereby authorize my financial institution to debit my account for all payments to Group Medical Services for payment of my premiums and any related fees, as may be determined from time to time, and which will be collected monthly in advance. This authorization may be cancelled at any time by providing written notice to Group Medical Services. However, I understand that I am purchasing an annual plan from Group Medical Services, and upon cancellation of this authorization, will ensure that any unpaid portion of the annual premium is remitted in full immediately.

NSF withdrawals will be handled in accordance with Group Medical Services' standard NSF Policy. Each payment will be treated as though I had personally issued a cheque authorizing payment to Group Medical Services as indicated and to debit the amount specified to my/our account.

Any delivery of this authorization to the above financial institution constitutes delivery by me.

This authorization may be cancelled at any time by providing written notice to Group Medical Services. However, I understand that I am responsible for remitting monthly premiums to Group Medical Services, and upon cancellation of this authorization, will ensure that any unpaid premiums are remitted in full immediately.

X _____ DD / MM / YYYY
Signature of Authorized Account Holder (in the case of a joint account, all depositor signatures must appear) Date

For Office Use Only: GMS ID#: _____ Date Received: DD / MM / YYYY