Group Medical Services

Pre-Authorized Debit (PAD)
Cancellation Notice

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	Date of Birth *(DD/MM/YYYY)*

B. 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*	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 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.*