PRE-AUTHORIZED DEBIT REQUEST for CATASTROPHIC HEALTH/TRAVEL MEDICAL PREMIUMS

Policy Numbers: 9226699 & 9226700	**Amount of Monthly Withdrawal: _____**	**Starting: 15th of _____, 200____**

BUSINESS Payor's Name & Address			**PERSONAL Payor's Name & Address**		
Company Name:			_____ *(Mr/Ms/Mrs) (Surname) (First)*		
Street:			**Street:**		
City/Prov	**Postal Code**	**Phone Number**	**City/Prov**	**Postal Code**	**Phone Number**
Name of Financial Institution:			**Name of Financial Institution:**		
Street:			**Street:**		
City/Prov	**Postal Code**	**Account Number**	**City/Prov**	**Postal Code**	**Account Number**
Payee's Name & Address			**Payee's Name & Address**		
Name: AVP Health & Welfare Trust			**Name: AVP Health & Welfare Trust**		
Street: 222, 855 – 42nd Avenue S.E.			**Street: 222, 855 – 42nd Avenue S.E.**		
City/Prov Calgary, Alberta	**Postal Code T2G 1Y8**	**Phone Number (403) 214-3213**	**City/Prov Calgary, Alberta**	**Postal Code T2G 1Y8**	**Phone Number (403) 214-3213**
Please attach a specimen VOID cheque to this Authorization					

1. **I/We acknowledge that the Authorization is provided for the benefit of the Payee and the Processing Institution and is provided in considerationof the Processing Institution agreeing to process debits against my/our account as listed above, (the "Account") in accordance with the Rules of the Canadian Payments Association.**
2. **I/We warrant and guarantee that all persons whose signatures are required to authorize withdrawals from the Account have signed the Authorization below.**
3. **I/We hereby authorize the payee to issue Pre-Authorized Debits (as defined in Rule H4 of the Rules of the Canadian Payments Association) – the "PAD" drawn on the Account for the purpose of insurance premium payment.**
4. **I/We may cancel the Authorization at any time upon providing written notice to the Payee.**
5. **I/We acknowledge that provision and delivery of the Authorization to the Payee constitutes delivery by me/us to the Processing Institution. Any delivery of the Authorization to the Payee, regardless of the method of delivery, constitutes delivery by me/us.**
6. **I/We acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of the Authorization including, but not limited to, the amount, or that any purpose of payment for which the PAD was issued has been fulfilled by the Payee as a condition to honoring a PAD issued or caused to be issued by the Payee on the Account.**
7. **I/We may only dispute a PAD under the following conditions (i) the PAD was not drawn in accordance with the authorization or (ii) the Authorization was revoked. I/We acknowledge that in order to be reimbursed a declaration to the effect that either (i) or (ii) took place, must be completed and presented to the branch of the Processing Institution holding the Account up to and including 10 calendar days after the date on which the PAD in dispute was posted to the Account. I/We acknowledge that when disputing any PAD beyond the time allowed in this section it is a matter to be resolved solely between me/us and the Payee, outside the payments system.**
8. **I/We agree that the information contained in the Authorization may be disclosed to Royal Bank of Canada as required to complete any PAD transaction.**
9. **I/We understand that The Trust is NOT responsible for premium paid on behalf of employees if they have not been notified.**
10. **Any PAD that is dishonored will be assessed a fee of $30.00 to be charged against your account. If a subsequent PAD is dishonored within 12 months, the PAD service will be discontinued.**
11. **I/We understand and accept the terms of participating in this PAD plan.**

_____ _____ _____

Date **Company Name** ***(if applicable)*** **Signature**