PRE-AUTHORIZED DEBIT (PAD) AGREEMENT for: **ALPA Canada Insurance Trust voluntary insurance coverage**

Please print, complete and sign

MEMBER INFORMATION

Last Name	Given Name	Initials	Employer/Airline (optional)

STEP 1 PROVIDE DETAILS FOR MONTHLY PRE AUTHORIZED DEBITS

ATTACH A PERSONALIZED 'VOID' CHEQUE **OR** COMPLETE THE INFORMATION BELOW

ACCOUNT DETAILS

Name(s) of Account Holder(s) as shown on Financial Institution records

Street Address of Account Holder(s)	City	Prov.	Postal Code

Name of Financial Institution

Street Address of Branch	City	Prov.	Postal Code

Financial Institution Number	Transit Number	Account Number

WITHDRAWAL ARRANGEMENT

Variable [✓] Fixed [ ]

STEP 2 REVIEW AND PROVIDE AUTHORIZATION

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.

AUTHORIZATION FORM MUST BE SIGNED IN INK

I/We, the Account Holder(s), authorize Professional Pilot Insurance Plan (PPIP) and the financial institution named above or as indicated on the attached "VOID" cheque to withdraw variable monthly payments from my/our account, at the branch indicated, for the purpose of collecting premiums and any applicable provincial sales tax and service charges for the insurance under this insurance program.
The PAD amount will be debited from the account indicated above on the 1st day of each month or the next business day. I/We agree to notify the plan administrator below in writing, if there is any change to the banking information set out above.

I/We waive the right to receive pre-notification of the amount to be debited each month and the date of such debit. The Administrator will provide notification to the plan member of the amount of the PAD at least three(3) calendar days before the first PAD is debited and before any increase to the PAD amount is debited, except when the increase is due to a change in sales taxes, service charges, or the increase to the PAD amount is a result of my/our request.

I/We may cancel this PAD Agreement at any time, subject to providing notice to the Plan Administrator (TPA) at the address provided below. This notification must be received at least ten (10) business days before the next debit is scheduled. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.
I/We understand that cancellation of this PAD Agreement will not have any effect on the insurance provided under this policy, provided that payments are received when due and is made in accordance with the terms of this insurance program. This PAD Agreement only applies to the method of payment. I/We understand that completing this PAD Agreement does not mean that the application for insurance has been approved.

X		X	
ALPA MemberSignature (must always sign)	Date (dd-mmm-yyyy)	**Signature of all other Account Holder(s)** (if a required signatory to this account)	Date (dd-mmm-yyyy)

PLEASE SEND YOUR COMPLETED FORM TO:

RBI Advisory Group
Box 89, Station Main, Okotoks, AB T1S 1A4

FAX / EMAIL to:

Contact us toll-free at **1-888-724-1444**
Monday to Friday from 08:30 to 16:30 (Mountain Time)
or email general@rbiadvisory.com fax 403 938 0232