Retiree Plans

DIRECT DEPOSIT AUTHORIZATION / REQUEST FOR PRE-AUTHORIZED PAYMENT

Please indicate your Firm & Certificate #

Firm #	Certificate #

Covered Individual's Full Name ____________________

COMPLETE THE APPLICABLE SECTIONS TO CHANGE YOUR FINANCIAL INSTITUTION ACCOUNT INFORMATION

❑ DIRECT DEPOSIT AUTHORIZATION

Identify the account you want to use to receive benefit payments directly from Johnston Group Inc. The account you choose must have chequing privileges. **IMPORTANT: Send this completed form to us along with a sample cheque marked "VOID". Without a sample cheque, we do not have the account codes we need to make direct deposits on your behalf.**

Financial Institution Account Information

Account Number ____________________ Transit Number ____________________

Financial Institution ____________________

Branch Address ____________________

Authorized Signature ____________________ Date ____________________

I authorize Johnston Group Inc. to deposit benefits payable to me to the account I have elected. I can cancel this authorization at any time by writing to the National Service Centre. **I have attached a sample cheque, marked "VOID", to provide the Financial Institution details necessary for direct deposit.** I understand that Johnston Group Inc. will provide an Explanation of Benefits statement to me explaining how each direct deposit amount has been calculated.

❑ REQUEST FOR PRE-AUTHORIZED PAYMENT

Financial Institution Account Information

Account Number ____________________ Transit Number ____________________

Financial Institution ____________________

Branch Address ____________________

Authorized Signature ____________________ Date ____________________

THE ACCOUNT YOU CHOOSE MUST HAVE CHEQUING PRIVILEGES.

I authorize Johnston Group to make withdrawals for the payment of monthly premiums. I authorize Johnston Group to debit the account on the 1st day of each month. **I have attached a sample cheque, marked "VOID" to verify the necessary Financial Institution account details.** The monthly debit is for group insurance premium. The amount may be variable and I will receive notice of the debit approximately 3 business days before the 1st of each month. However, I will not receive notice of subsequent months' debits until such time as the amount changes. I understand that this agreement may be revoked at any time by providing 30 days written notice. I understand that I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this agreement. I understand that I may obtain further information on my right to cancel / recourse rights by contacting my financial institution, or by visiting www.cdnpay.ca.

Covered Individual's Signature ____________________ Date ____________________

NATIONAL SERVICE CENTRE
1051 King Edward Street, Winnipeg, MB R3H 0R4 • 1-800-893-7587

Underwritten by Group Medical Services (GMS).

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