

Please complete this form only if you wish to pay premiums by pre-authorized debit (PAD). There are no additional charges for paying on a monthly basis – the annual premium is simply divided by 12 months.

Policyholder information

Your first name	Last name	OMA reference number
If applicable, online application confirmation number (REQUIRED)		

Payor information

Complete this section if someone other than you, including a corporation, is paying for your policy. Please include all joint account holder information, if applicable.

Payor(s) name (first and last) or full legal name of corporation/entity			
If applicable, date of birth (dd-mm-yyyy)	Relationship to you		
Address (street number and name)			Apartment or suite
City	Province	Country	Postal code

Payment options

- Annually (not applicable to Flex 10 policy G-29700, Flex 20 policy G-29800, policy 50130, and policy 50131)
- Monthly, 1st day of the month

Transit #	Institution #
Account #	
<input type="text" value="Your Transit #"/>	<input type="text" value="Institution #"/>
<input type="text" value="Account #"/>	

Policy selection

Please indicate which policy(ies) this update applies to:

- All
- Other: please indicate your policy number(s) here: _____

Continue to page 2, read the authorization and sign where indicated. Please mail us the completed form or fax it to 1-800-367-0813.



Authorization

To use Pre-Authorized Debit (PAD) you must agree to all the terms of the authorization. By signing below as payor you agree to the following terms and conditions:

Terms and conditions

You authorize the OMA Insurance/Group Plan Administrator to collect the annual or monthly premium (including applicable provincial tax), depending on your selection above, for this insurance through a Pre-Authorized Debit (PAD) from the account referenced on your enclosed blank cheque marked void. You acknowledge that your financial institution may treat any withdrawal pursuant to this authorization as a withdrawal for **personal** services. You acknowledge that the amount of the premium (including applicable provincial tax) collected through this agreement may vary, reflecting any changes, additions or deletions in plan coverage as well as premium rate changes. **You agree to waive the requirement that the OMA Insurance / Group Plan Administrator notify you of any payments after the first payment whether the amount of the monthly or annual premium is changed or not.** You understand that if you selected to pay your premium annually, premium will be due with your annual renewal. If you selected to pay your premium monthly, it will be due on the first day of each month. This agreement will be cancelled automatically if the OMA Insurance/Group Plan Administrator is unable to make a withdrawal from your account.

This authorization is to remain in effect until the OMA Insurance/Group Plan Administrator has received written notification from you of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. You may obtain a sample PAD cancellation form, or more information on your right to cancel a PAD Agreement at your financial institution or by visiting www.payments.ca.

The OMA Insurance/Group Plan Administrator may not assign this authorization to another company or person to permit them to debit your account for these payments (for example where there has been a change in control of the company) without providing at least 10 days prior written notice to you.

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.payments.ca.

OMA Insurance

P.O. Box 365 Stn Waterloo

Waterloo ON N2J 4A4

Telephone # 1-800-758-1641

Fax # 1-800-367-0813

Email: Can_AssocAndAffinity@sunlife.com

I/we confirm that all persons whose signatures are required to authorize bank withdrawals have signed below.

Your first and last name	Your signature X	Date signed (dd-mm-yyyy) — —
Payor(s) name	Payor(s) signature (if applicable) X	Date signed (dd-mm-yyyy) — —
Joint account holder(s) name	Signature of joint account holder (if both signatures required) X	Date signed (dd-mm-yyyy) — —