

Section A – Plan member's personal information				
LAST NAME	FIRST NAME	PLAN MEMBER'S PERSONAL HEALTH NUMBER (PHN)	HOME PHONE NUMBER	WORK PHONE NUMBER
MAILING ADDRESS		CITY/TOWN	PROVINCE	POSTAL CODE

Section B – Bank account holder's information				Same as plan member? <input type="checkbox"/> yes <input type="checkbox"/> no	
NAME OF FINANCIAL INSTITUTION	FINANCIAL INSTITUTION NUMBER	BRANCH TRANSIT NUMBER	BANK ACCOUNT NUMBER		
BRANCH ADDRESS		CITY/TOWN	PROVINCE	POSTAL CODE	
BANK ACCOUNT HOLDER NAME, ADDRESS AND PHONE NUMBER (if different from plan member)					

For verification, please attach a blank cheque marked "VOID." If you do not have a cheque, please have a representative of your financial institution certify, below, that the bank account information you have provided is correct.

I certify the accuracy of the above branch, institution and account number.		<i>Branch Stamp of Financial Institution</i>
<hr/> Signature of financial institution representative		<div style="border: 1px solid black; width: 150px; height: 100px; margin: 0 auto;"></div>
<hr/> Print name of representative		

Section C – Options
1. Please select a Preauthorized Payment withdrawal date: <input type="checkbox"/> 1st day of each month <input type="checkbox"/> 15th day of each month 2. Please select one of the following two options: <input type="checkbox"/> Please send notification only if premiums are changing. <input type="checkbox"/> Please send quarterly premium statements. 3. Type of service: <input type="checkbox"/> Personal <input type="checkbox"/> Business

Section D – Authorization (if more than one bank account holder, both bank account holders' names and signatures required)		
I, the bank account holder, agree to the terms and conditions of authorization established by the Alberta Blue Cross Non-Group Coverage Plan as outlined on the back of this form. I authorize Alberta Health and Wellness to automatically withdraw funds from my bank account for payment of premiums on the Plan Account.		
<hr/> Signature of bank account holder	<hr/> Print name	<hr/> Date
<hr/> Signature of bank account co-holder	<hr/> Print name	<hr/> Date
If this is notification of your bank account changing, please indicate the effective date: _____ / _____ / _____ (yyyy/mm/dd)		

If you have questions, please contact Non-Group Coverage Administration at 780-498-5970 (Edmonton and area) or 1-888-498-5970.

Please submit the completed form by fax or mail.	FAX: Non-Group Coverage Administration 780-498-3532 or toll free 1-877-220-3532	MAIL: Non-Group Coverage Administration Box 29000 Stn Main Edmonton AB T5J 0B8
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TERMS AND CONDITIONS OF AUTHORIZATION

Definitions

- “I,” “me” and “my” means each person who signs this Authorization, jointly and severally.
- “Bank Account” means the Account identified in Section B on the front of this form.
- “Non-Group Coverage Plan” means the supplementary health benefits plan sponsored by the Government of Alberta and administered by the ABC Benefits Corporation, operating as Alberta Blue Cross.
- “PPP” means a Preauthorized Payment Plan as described in this Authorization.
- “Plan Account” means the Non-Group Coverage Plan Member’s Account (see Section A).

Scope. I acknowledge that this Authorization is provided for my benefit and the benefit of Alberta Health and Wellness and my financial institution and is provided in consideration of my financial institution agreeing to process debits against my bank account in accordance with the rules of the Canadian Payments Association.

Valid signing authority. I warrant that all persons whose signatures are required on the bank account have signed Section D on the front of this form.

Authority to debit bank account. I authorize Alberta Health and Wellness to automatically withdraw funds from my bank account for payment of premiums owing on the Plan Account. I understand and agree that the PPP will increase or decrease according to the current monthly premium rates billed on the Plan Account. Notice of changes to monthly premiums can be sent to the address listed on the Plan Account. Alberta Blue Cross will provide notice in writing at least 10 calendar days before each and any change to the monthly PPP withdrawal amount.

Processing date. PPP transactions will occur on the 1st or 15th of each month (as indicated in this Authorization), or the next business day if the 1st or 15th occur on a weekend or holiday. Alberta Blue Cross will send a written notice at least 10 calendar days prior advising of the date the first transaction will occur to the address listed on the Plan Account. Alberta Blue Cross will provide notice in writing at least 10 calendar days before each and any permanent change in the monthly processing date. I agree I may change my processing date once per calendar year if I deliver written notice to Alberta Blue Cross by the 20th day of the month, to be effective the following month.

Change to bank account. I certify that the bank account information I have provided is accurate. I agree to inform Alberta Blue Cross, in writing, of any change in my bank account information at least 21 days prior to the next PPP withdrawal date.

Cancellation by me. I may cancel this Authorization at any time by notifying Alberta Blue Cross (at the address or telephone numbers listed on the form) at least 21 days prior to the date of the next PPP withdrawal. Cancellation does not terminate the health care coverage under the Plan Account, but only affects the method of payment for that coverage. (*Note: A sample cancellation form or further information on your right to cancel this agreement may be obtained at your financial institution or by visiting www.cdnpay.ca.*)

Cancellation by Alberta Health and Wellness. I understand Alberta Health and Wellness may cancel this Authorization immediately, without notice to me or the Plan Member, if the PPP withdrawal is returned unpaid by my financial institution for any reason.

Acceptance of delivery of authorization. I acknowledge that providing and delivering this authorization to Alberta Blue Cross constitutes delivery by me to my financial institution.

Validation by financial institution. I agree that my financial institution is not required to verify that any PPP has been withdrawn in accordance with this Authorization, including the amount, frequency and fulfillment of purpose of any PPP.

My dispute rights. I may dispute a PPP if any of the following occurs: (a) the PPP was not drawn in accordance with this Authorization; (b) this Authorization was revoked; or (c) pre-notification of a change to the monthly withdrawal amount or date was not received. In order to be reimbursed, I acknowledge that a declaration to the effect that either (a), (b) or (c) took place must be completed and presented to the branch of my financial institution where my bank account is located within 90 calendar days after the date the PPP in dispute was posted to my bank account. If I am disputing a PPP after this 90 day period, I will resolve any dispute with Alberta Blue Cross.

Collection of information. The information on this Authorization is collected pursuant to section 20 of the *Health Information Act* and section 33 of the *Freedom of Information and Protection of Privacy Act* for the purpose of processing premium payments owed for the Non-Group Coverage Plan sponsored by the Government of Alberta. If you have any questions regarding the collection or use of this information, please contact an Alberta Health and Wellness representative by fax or mail as indicated on the front of this form or by telephone at 780-498-5970 (Edmonton and area) or 1-888-498-5970 (toll free).

Please retain a copy of this registration form for your records.