the co-operators®
A Better Place For You®

GROUP BENEFITS REQUEST FOR PRE-AUTHORIZED DEBIT (PAD) PLAN

AVAILABLE ONLY TO POLICYHOLDERS WITH A MINIMUM WITHDRAWAL OF $5.00 PER MONTH

In order to avoid delays, please ensure that all required information is provided.

1. GROUP EMPLOYEE BENEFITS

To ensure accuracy, attach a void cheque in upper right corner.

Pre-Authorized Debit Plan withdrawals are the 1st of each month.

Retain a copy for your records.

☐ I have waived my right to receive pre-notification of the amount of the Pre-Authorized Debit (PAD) Plan and agreed that I do not require advance notice of the amount of the PADs before the debit is processed.

Group _____ Account _____

Plan Sponsor _____

Financial Institution Name _____

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Transit ☐☐☐☐☐ (5 digits) Institution ☐☐☐ (3 digits) Account ☐☐☐☐☐☐☐☐☐☐☐☐ (maximum 12 digits)

2. AUTHORIZATION

CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Your Payor's PAD agreement may be cancelled provided notice is received 14 days before the next scheduled PAD. If any of the above details are incorrect, please contact us immediately at 1-800-667-8164. If the details are correct, you do not need to do anything further and your Pre-Authorized Debits will be processed and start on the Payment Start Date indicated above.

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 PAD that is not authorized or is not consistent with the terms of this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.

I hereby authorize Co-operators Life Insurance Company ("Co-operators") to withdraw premium payments from my account for the policy referred to herein and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid for so long as my coverage remains in effect unless revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Depositor Signature _____ Date _____ (MMM/DD/YYYY)

2nd Depositor Signature (if Joint Account) _____