HSA Pre-Authorized Payment (PAP) Plan Agreement

Please read and complete the Pre-Authorized Payment Plan Agreement below.

I/We authorize Benecaid Health Benefit Solutions Inc., and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our Benecaid Health Spending Account. Regular payments for the full amount of services delivered will be deducted from my/our specified account on the 25th day of the month per my/our Health Spending Account contribution schedule. Benecaid Health Benefit Solutions Inc. will provide five (5) days written notice of the amount of regular debit. Benecaid Health Benefit Solutions Inc. will obtain my/our authorization for any other one-time or sporadic debits.

This authority is to remain in effect until Benecaid Health Benefit Solutions Inc. has received written notification from me/us 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. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAP Agreement at my/our financial institution by visiting www.cdnpay.ca.

Benecaid Health Benefits Solutions Inc. may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least ten (10) days prior written notice to me/us.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAP that is not authorized or is not consistent with this PAP agreement. To obtain a form for reimbursement claims, or for more information on my/our rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

PLEASE PRINT **DATE**: ________________________

PAP Category: BUSINESS

Benecaid HSA Group Policy # (for existing clients): ______________________________

Company Name: ____

Company Street Address: ____ Unit #: ______________

City: ____________________________________ Province: ____________________ Postal Code: ______________

Phone Number: ______________________________

Designated Financial Institution: ____

FI Code: _________ (3 digits) Transit: ________________ (5 digits) Account: ______________________________

Name of Signing Officer(s): ____

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Authorized Signature(s): ____

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PLEASE ATTACH A VOID CHEQUE

Benecaid Health Benefits Solutions Inc.
Attn: Data Management Department
PO Box 40
Toronto, ON M9C 4V2