Alberta Government

REGISTRATION FOR PREAUTHORIZED MONTHLY PAYMENT

Alberta Blue Cross Non-Group Coverage

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? ☐ yes ☐ 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.

Branch stamp of financial institution

Signature of financial institution representative

Print name of representative

SECTION C – OPTIONS

1. Please select a preauthorized payment withdrawal date: ☐ 1st day of each month ☐ 15th day of each month

Premium statements are not sent to individuals who are registered for preauthorized payment. If premiums are changing, advanced notification will be sent. A receipt of payment that may be used for tax purposes is available on our member website. To register for access to the site, sign up today at ab.bluecross.ca

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 to automatically withdraw funds from my bank account for payment of premiums on the Plan Account.

Signature of bank account holder | Print name | Date

Signature of bank account co-holder | Print name | 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 this 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

Administered by ALBERTA BLUE CROSS®

TERMS AND CONDITIONS OF AUTHORIZATION

Definitions

- "I," "me" and "my" means the person who acknowledges these terms and conditions, jointly and severally.
- "Bank Account" means the Account provided.
- "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.

Scope. I acknowledge that this Authorization is provided for my benefit and the benefit of Alberta Health 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.

Authority to debit bank account. I authorize Alberta Health 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 will be sent using the preferred communication method that has been selected on the Plan Account. Alberta Blue Cross will provide notification 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 notification at least 10 calendar days prior advising of the date the first transaction will occur using the preferred communication method that has been selected on the Plan Account. Alberta Blue Cross will provide notification 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 Non-Group Administration 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 cdnpay.ca.)*

Cancellation by Alberta Health. I understand Alberta Health 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 representative at 780-427-1432 or toll free at 310-0000 and then 780-427-1432.

Please retain a copy for your records.