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PAYMENT PLAN AUTHORIZATION FORM

Policyholder Full Name & Address:	Policy Number:
	Policy Start Date:
	Agent Broker Name:
Tel Number:	

Axiom Mutual Insurance Company offers several payment options for your convenience. Payment option changes may only be applied at time of renewal.

PLEASE PICK THE PAYMENT OPTION THAT'S RIGHT FOR YOU:

ONE PAY - 100% due on policy date \$ _____ Recurring Annually

3 PAY - No administration fee, 3 equal monthly payments taken consecutively starting on your policy effective date

QUARTERLY - Farm policies only, 4 equal payments every 3 months, 1% administration fee

MONTHLY - 12 monthly charges/withdrawals, 1% administration fee

PLEASE COMPLETE ONE:

CREDIT CARD INFORMATION & AUTHORIZATION:

Visa Mastercard Credit Card # _____ - _____ - _____

Cardholder's Name _____ Expiry ____ / ____ (mm/yy) CVV # _____

Cardholder's Signature _____ Withdrawal 1st 12th 15th 26th of the month

CHEQUING ACCOUNT & AUTHORIZATION: * Attach a sample cheque, marked VOID or bank confirmation *****

Account Holder's Name: _____ Withdrawal Date: _____ of the month

Financial Institution: _____ Transit # _____ Bank # _____ Account # _____

2nd automatic withdrawals are attempted. A fee of \$25 will be charged on all NSF payments or Declined credit card payments.

Consent & Disclosure

I/we authorize Axiom Mutual Insurance Company and the financial institution designated (or any other financial institution I/we my authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments and/or one-time payments from time to time, for payment of insurance premium. Axiom Mutual Insurance Company will provide 10 business days written notice of the amount of each regular withdrawal. Axiom Mutual Insurance Company will obtain my/our authorization for any other one-time or sporadic debits. All amounts debited will be in Canadian funds. The payment amount may vary from month to month and will be according to the Amount Due on the most recent Billing Statement. Pre-notification of amount changes will be disclosed in a revised Billing Statement at least 10 business days prior to the next scheduled Payment date. See above for additional fees that may be applied.

This authority is to remain in effect until Axiom Mutual Insurance Company has received written notification from me/us of its change or termination. This notification must be received at least 10 (ten) business days before the next withdrawal is scheduled at the address provided above. I/we may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

Axiom Mutual Insurance Company may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without giving at least 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 PAD that is not authorized or is not consistent with this PAD agreement. To obtain a form for a Reimbursement Claim or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

AUTHORIZED SIGNATURE: _____

DATE: _____

AUTHORIZED SIGNATURE: _____

DATE: _____