DIRECT DEBIT BANKING AUTHORIZATION AND/OR CHANGE

Name: ______________________ **Doctors of BC ID #:** ____________ **MSP #** ___________
(Please Print)

I/we hereby authorize Doctors of BC to withdraw the dues and/or premiums for the programs indicated below from the bank account(s) designated on this form, and if applicable, I/we authorize the change of my/our existing bank account records with the new information provided on this form. I have attached (or previously provided) an unsigned cheque(s) marked VOID or a screen-print of my bank account details including Institution code, Transit and Account Number for the account(s) to be used for the following program(s):

Check all Program(s) you are enrolled in, for which you are authorizing Direct Debit.	Check ONE bank account for each Program you are enrolled in.		
	Personal Bank Account		Corporate Bank Account
❑ Life	❑	or	❑
❑ Accidental Death & Dismemberment	❑	or	❑
❑ Professional Expense (Office Overhead)	❑	or	❑
❑ Critical Illness[1]	❑	--	N/A
❑ IncomeProtect Disability Insurance[1]	❑	--	N/A

[1]For tax reasons a personal account must be used to pay for Critical Illness and Disability Insurance.

NEW BANK ACCOUNT:	❑ PERSONAL ACCOUNT – Void Cheque Attached
	❑ CORPORATE ACCOUNT – Void Cheque & Copy Certificate of Incorporation Attached (if not previously submitted)
BANK ACCOUNT ALREADY ON RECORD WITH DOCTORS BC:	❑ PERSONAL ACCOUNT # ________________(Void cheque previously submitted)
	❑ CORPORATE ACCOUNT # ________________(Void cheque previously submitted)

I/we will notify Doctors of BC in writing of any changes in the account information or termination of this authorization at least thirty (30) days prior to the next payment date. My/our financial institution will treat each debit as if I/we had personally issued a written direction authorizing Doctors of BC to debit the amount(s) specified to my/our account and need not verify that payments are drawn in accordance with this authorization. I/we acknowledge that delivery of this authorization to Doctors of BC constitutes delivery to my/our financial institution. I/we warrant that all persons whose signatures are required to sign upon this account have signed this authorization.

X ____
(Signature) ***(Date)***

X ____
(Signature** [2]- joint personal bank account holder)* ***(Date)

X ____
(Signature** [2]- joint corporate bank account holder)* ***(Date)

[2]For joint accounts, all depositors must sign if more than one signature is required on cheques issued against the account.

115 - 1665 West Broadway Vancouver, BC V6J 5A4 T 604.638.2904 F 604.638-2909 www.doctorsofbc.ca