BCMA HEALTH BENEFITS TRUST FUND

HBTF PLAN AND OPTIONAL COST-PLUS PLAN DIRECT DEBIT AUTHORIZATION FORM

doctors of bc
British Columbia Medical Association

Personal Information

Name: _____
(please print)

Please indicate your e-mail address for payment confirmation purposes:

E-mail Address: _____

I (we) hereby authorize Doctors of BC as Administrator of the Trust Fund to withdraw my monthly Plan premium directly from my (our) bank account. ***I have attached a cheque unsigned and marked VOID for the account to be used for this purpose.***

Bank Account Type:

- ☐ Personal (attach void Personal cheque)
- ☐ Corporate (attach void Corporate cheque **AND** Certificate of Incorporation)
- ☐ Cost-Plus Plan* (attach both a Personal **AND** Corporate void cheque **AND** Certificate of Incorporation)

*If you are enrolling employees in the Cost-Plus Plan, please also attach a void personal cheque from each employee

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. If I am not incorporated, I have designated the Personal Account I use for my business expenses, or if I do not have any business expenses, my Personal Account. I will also notify Doctors of BC in writing if I am no longer working as a physician or if my residence should no longer be in British Columbia.

I/we understand that termination of this authorization does not affect my/our obligation to pay for goods or services contracted for/with Doctors of BC.

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 understand that any debits charged to my/our account will be reimbursed if:

a) the debit was not drawn in accordance with this authorization;
b) this authorization has been terminated;
c) the debit was posted to the wrong account due to invalid/incorrect account information supplied by Doctors of BC;

by giving notice in writing to my/our branch of account within ninety (90) days of the debit to my/our account.

I/we acknowledge that delivery of this authorization to Doctors of BC constitutes delivery to my financial institution.

Signature(s)

I/we warrant that all persons whose signatures are required to sign upon this account have signed this authorization.

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

A photocopy or electronic version of this authorization is as valid as the original.

_____ Signature mm dd yyyy

_____ Signature mm dd yyyy

TO BE COMPLETED BY DOCTORS OF BC ON BEHALF OF THE TRUST FUND – DO NOT WRITE IN THIS AREA

Doctors of BC Business ID: _____

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TF 1 800 665 2262
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doctorsofbc.ca