Allstate Insurance Company of Canada
Allstate Benefits
PO Box 8100 Stn T
Ottawa, ON K1G 3H6
1-844-436-1105

Pre-Authorized Debit (PAD) Agreement

Use this form for authorization to electronically deduct funds from your account to pay for Allstate Benefit coverages.

1. Group/Payor Information

Name of Group/Participating Employer:_____

Group Policy Number:_____ Division Number:_____

2. Account Information – or attach void cheque

Name of Financial Institution:_____

City:_____ Province:_____ Postal Code:_____

Branch Transit Number_____ Financial Institution Number_____

Account Number_____

3. Authorization

I authorize Allstate Benefits to initiate debit entries electronically to my account monthly in the amounts indicated above **(variable amount)** and any applicable taxes **on or about the 1st business day of every month**, and I authorize the financial institution named above to debit same to such account. This authorization remains effective and in full force until Allstate Benefits and the financial institution have received written notification from me of its termination in such time and in such manner to afford Allstate Benefits and the financial institution a reasonable opportunity to act on it.

I have waived the right to pre-notification of at least 10 days before my first PAD; however Allstate Benefits will send me monthly written invoices identifying any new premium amount/rate change at least 10 days before each and any change in the amount of my PAD.

My authorization may be revoked at any time in writing, subject to providing a notice period of 30 days to Allstate Benefits. To obtain a sample cancellation form or for information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca.

I understand I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. If I wish to obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Account Holder/Policy Owner Signature:_____ Date:_____

Joint Account Owner Signature (if applicable):_____ Date:_____

4. Deliver this authorization to:

Fax to: 1-844-436-1107
Attn: Allstate Benefits

Toll-free phone: 1-844-436-1105

Mail to: Allstate Insurance Company of Canada
Allstate Benefits
PO Box 8100 Stn T
Ottawa, ON K1G 3H6