CANADIAN BENEFIT PROVIDERS

ELECTRONIC PAYMENT AUTHORIZATION, MEMBER

- Use this form to authorize payment for claims directly to your bank account via electronic fund transfer.

PART 1 | MEMBER AND GROUP INFORMATION (All fields are mandatory)

PLAN SPONSOR/GROUP NAME			
PLAN MEMBER NAME (Last Name, First Name)			
GROUP #		MEMBER ID #	
PRIMARY PHONE		EMAIL	

PART 2 | BANK ACCOUNT INFORMATION

Choose one of two options for payment. Effective Date (mm/dd/yyyy): ☐

☐ OPTION 1: ATTACH VOID CHEQUE

I authorize all claim payments to be deposited into the bank account indicated on this cheque.

☐ OPTION 2: YOUR BANK'S DIRECT DEPOSIT FORM

I authorize all claim payments to be deposited to the bank account indicated on the attached direct deposit form from my bank.

AUTHORIZATION & DECLARATIONS

Whereas the "Company" refers to Canadian Benefit Providers Inc., **I certify** that the information in this form is true and complete to the best of my knowledge. **I acknowledge** and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information. **I authorize** the collection, use, maintenance and disclosure of personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this informa-tion with each other and with my Plan Advisor, its reinsurers and/or its service providers, for the Purposes. **I understand** that any Information provided to or collected in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to: Plan Advisor employees, representatives, reinsurers, and service providers in the performance of their jobs; Persons to whom I have granted access; and Persons authorized by law. I authorize all future claims payments to be sent via electronic funds transfer to the bank account listed here. **I agree** that I will access my Explanation of Benefits via the secured employee web portal and that I will maintain a current email address to receive notification of payments as they occur. **I recognize** that it is my responsibility to ensure that my file is kept up-to-date with my preferred bank account information and personal information. **I agree** that the Company will not be responsible for any payments that are lost or misdirected due to incorrect banking information. **I designate** the person(s) named under the Beneficiary Designation as my beneficiary. **I authorize** the deduction from my pay of any contributions I must make towards the cost of these benefits. **I agree** that a photocopy or electronic version of this authorization is valid.

PLAN MEMBER'S SIGNATURE	DATE (mm/dd/yyyy)

Forward this completed form by email, fax or mail to:
Email | admin@cbproviders.ca Fax | 1.844.944.9168
Mail | Canadian Benefit Providers 301-8925 51 AVE NW EDMONTON AB T6E 5J3 Canada