FORM 01

Option & Payment Form

Please complete all information requested below, sign and return to:
AFBS, 1000 Yonge Street, Toronto, Ontario M4W 2K2

AFBS: 1000 Yonge Street
Toronto, ON M4W 2K2
PHONE: 416-967-6600 1-800-387-8897
FAX: 416-967-4744 1-888-804-8929
E-MAIL: benefits@afbs.ca

AFBS WEST: 320 -1155 Pender Street West
Vancouver, BC V6E 2P4
PHONE: 604-801-6550 1-866-801-6550
FAX: 604-801-6580
E-MAIL: afbswest@afbs.ca

SECTION 1 – Member Information *(please print)*

Reset Form

Member Name (Last, First, Middle Initial)	Telephone Number	Date of Birth

Your Account Number	ACTRA/WGC Number
4501 ☐ ☐ ☐ ☐ ☐ ☐	

SECTION 2 – Insurance Options

Please refer to your Insurance Options outlined on your Insurance Statement when completing this form. To be accepted for processing by AFBS, this form must be post-marked or received by AFBS no later than midnight (EDT) March 31st, 2015.

Please select **one** option from your **Insurance Statement**, as applicable.

Option Number	Amount Due, *if applicable*

SECTION 3 – Payment Options

Please complete this section if an additional premium payment is due to AFBS.
You may pay the amount due by cheque, Visa or MasterCard, or choose the monthly pre-authorized debit (PAD) payment option.

I will be paying the full amount due ☐ ***By cheque*** (Please make your cheque payable to **AFBS**.)

By Credit Card: ☐ ***Visa*** ☐ ***MasterCard*** ***(Members registered at the AFBS website may choose to pay their amount due online.)***

Cardholder's Name	Card Number	Expiry Date

Cardholder's Signature (Required)

☐ ***I will be paying the amount due by pre-authorized debit (PAD):*** A cheque for **two months'** premium made payable to **AFBS** plus a 'void' cheque **must** accompany this application. Further payments will be withdrawn from your account on the **14th of each month or the next business day** commencing in April and concluding the next January.

To calculate Your Payment Due Now, divide the Amount Due on your Insurance Statement by 12 and multiply by 2.

FOR EXAMPLE:

Amount Due (EXAMPLE ONLY)		Months (EXAMPLE ONLY)		Total per Month (EXAMPLE ONLY)		Payment Due Now (EXAMPLE ONLY)
$1,234.00	÷	12	=	$102.83	x 2 =	$205.66

Fill in YOUR information from YOUR Insurance Statement here:

Amount Due		Months		Total per Month		Your Payment Due Now
	÷	12	=	$0.00	x 2 =	$0.00

SECTION 3 – Payment Options *(continued)* **PLEASE TURN OVER**

Underwritten by:
Actra Fraternal Benefit Society: 1000 Yonge Street, Toronto, Ontario M4W 2K2
Telephone: (416) 967-6600 / Toll Free: 1-800-387-8897 Fax: (416) 967-4744 / Toll Free Fax: 1-888-804-8929
E-mail: benefits@afbs.ca Website: afbs.ca

FORM 01

Option & Payment Form

SECTION 3 – Payment Options *(continued)*

Pre-authorized debit (PAD) details:

Please debit my bank account for the amount indicated. I have attached a 'void' cheque and understand that this amount will be debited from my account on the 14th day of each month or the next business day.

I, the Payor, authorize Actra Fraternal Benefit Society (AFBS) to debit the bank account identified on my 'void' cheque for the payment of my Member insurance benefits for which I have made application, including provincial retail sales tax as may be required, in order to keep my insurance benefits in place.

I, the Payor, may revoke this authorization at any time, subject to providing 30 days written notice to AFBS. I understand that revoking this authorization may affect my Member insurance benefits. (To obtain a sample cancellation form, or for more information on your rights to cancel a PAD agreement, contact your financial institution or visit www.cdnpay.ca.)

I, the Payor, have certain recourse rights if a 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. (To obtain information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.)

Name of Accountholder (please print)	**Signature of Accountholder (required)**	Date DD MM YYYY
Name of Joint Accountholder (please print)	**Signature of Joint Accountholder (required)**	Date DD MM YYYY

THE PAYMENT OPTION AND INFORMATION PROVIDED IN THIS SUB-SECTION 'PAYMENT OPTIONS' IS VALID FOR ONE YEAR ONLY. NOTIFICATION WILL BE MAILED TO THE ADDRESS ON FILE WITH AFBS IN ADVANCE OF EACH BENEFIT YEAR ANNIVERSARY. CONTINUATION OF COVERAGE UNDER THE MEMBERS' INSURANCE PROGRAM MAY BE DEPENDENT ON THE RE-CONFIRMATION OF YOUR PAYMENT OPTION AND REMITTANCE OF THE APPROPRIATE PREMIUM DUE AT THAT TIME.

SECTION 4 – Member Authorization

I confirm that I wish to take advantage of the payment option indicated above and authorize payment of any additional premium, which may be due, plus retail sales tax as required. I understand that payment of any additional premium due for my chosen payment option may include a further deduction from my Insurance Account and a personal payment, both of which are indicated on the Insurance Statement issued to me.

I agree that a photocopy or electronic version of this form shall be as valid as the original.

I further confirm that this authorization is valid for the AFBS Benefit Year, March 1, 2015 to February 29, 2016.

Member's Signature (required)	Date DD MM YYYY

PLEASE NOTE THAT FAILURE TO SIGN THIS SECTION IMPLIES CONSENT.

When sending* this form to AFBS (not required with online credit card payment)

If you are paying by credit card or pre-authorized debit, please ensure that you have signed in the appropriate area of Section 3 – Payment Options. Your signature is required in Section 4 – Member Authorization.

Send* your **completed** and **signed** form to: **AFBS**, 1000 Yonge Street, Toronto, ON M4W 2K2

*When more convenient, the completed form may be mailed/dropped off at the AFBS western office for forwarding.

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