



**DIRECT DEPOSIT OF CLAIM BENEFITS  
GROUP INSURANCE**

<input checked="" type="checkbox"/> <b>Please select your request</b>		
<input type="checkbox"/> Initial Authorization <input type="checkbox"/> Modification		
<b>Member Identification</b>		
Policy Owner	Group	Certificate
Name	First name	
E-mail address		
<b>Authorization</b>		
<p>I hereby authorize <b>UV Insurance (The Union Life Mutual Assurance Company)</b>, to deposit my group insurance claim payments into my personal bank account identified on the attached void check. I certify that the foregoing information is accurate and complete, and I commit to inform <b>UV Insurance</b>, of any changes. I accept that this agreement may be cancelled by <b>UV Insurance</b>, or by myself upon written notice.</p>		
<b>Please attach a void check</b>		
Member's signature	Date	
<b>X</b>	D	M Y

**Please return the completed form to the following address:**

**UV INSURANCE**  
 P.O. BOX 696 DRUMMONDVILLE  
 (QUEBEC) J2B 6W9  
 TEL. : 819-478-1315  
 TOLL FREE : 1-800-567-0988  
 FAX. : 819-474-1990  
 WEB SITE : [www.uvinsurance.ca](http://www.uvinsurance.ca)