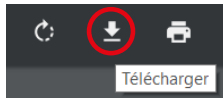


Steps to complete the form

1

Click on the download button for save the form on your computer.



2

Fill in the fields of the form and save your information before submitting it to us.

FIRST REQUEST MODIFICATION CANCELLATION

GROUP INFORMATION

| | | | |
|--------------------------------|--|----------------------|----------|
| NAME OF GROUP (Payer) | | GROUP NO. (Contract) | |
| ADDRESS (Number, Street, City) | | PROVINCE | ZIP CODE |

BANK INFORMATION *(Please attach a check with the mention "void" and provide the information requested below)*

| | | | |
|---|---------------------|--------------------|---------------------|
| NAME OF FINANCIAL INSTITUTION | TRANSIT 5 DIGITS | BRANCH 3 DIGITS | ACCOUNT 7 DIGITS |
| ADDRESS (Number, Street, City) | | PROVINCE | ZIP CODE |
| NAME OF AUTHORIZED SIGNATORY | TITLE | | |
| NAME OF SECOND AUTHORIZED SIGNATORY (If applicable) | TITLE | | |

DIRECT DEBITS INSTRUCTIONS *(Please use a different form for each instruction)*

THE AUTOMATIC DIRECT DEBIT WILL APPLY ON THE TOTAL AMOUNT CHARGED IN THE MONTHLY INVOICE ACCORDING TO BENEFITS INSURED UNDER THE PROVISIONS OF THE CONTRACT.

| | |
|---|---|
| DESIRED DAY FOR DIRECT DEBITS: <input type="checkbox"/> THE 1 ST DAY OF EACH MONTH (CHOICE BY DEFAULT) <input type="checkbox"/> THE _____ DAY OF EACH MONTH (BEFORE THE 15 TH OF THE MONTH) | APPLICABLE FOR : <input type="checkbox"/> ALL DIVISIONS <input type="checkbox"/> FOLLOWING DIVISIONS: _____ |
|---|---|

THE FIRST DIRECT DEBIT COULD INCLUDE THE PREMIUM OF TWO MONTHS, DEPENDING ON THE DATE THE REQUEST IS RECEIVED.

AUTHORIZATION AND SIGNATURE(S)

I, THE UNDERSIGNED, HEREBY IN MY CAPACITY OF SIGNATORY OF THE BANK ACCOUNT IDENTIFIED ABOVE, AUTHORIZED **UL MUTUAL** TO MAKE MONTHLY DIRECT DEBITS OF GROUP INSURANCE PREMIUMS IN COMPLIANCE WITH INSTRUCTIONS MENTIONED ABOVE. I UNDERSTAND THAT THE AMOUNT DEBITED DEPENDS ON BENEFITS EFFECTIVE AT THE MOMENT OF INVOICING. I AM AWARE THAT FEES OF \$ 25,00 WILL BE ADDED TO THE AMOUNT CHARGED EVERY TIME A PAYMENT BY DIRECT DEBIT IS NOT HONORED. I CONFIRM THAT INFORMATION INDICATED ON THIS FORM IS CORRECT AND I UNDERTAKE TO INFORM UL MUTUAL, IN WRITING, OF ANY CHANGE. I AGREE THAT THIS DIRECT DEBIT AGREEMENT CAN BE CANCELLED BY UL MUTUAL OR BY ME IN A WRITTEN NOTICE THAT WOULD HAVE TO BE RECEIVED WITHIN AT LEAST 10 BUSINESS DAYS BEFORE THE DUE DATE OF THE NEXT DIRECT DEBIT.

| | |
|-------------------------------------|------------------------|
| BY | DATE YYYY - MM - DD |
| BY (second signatory if applicable) | DATE |

555 (2015-01) UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.

RETURN TO:

| |
|--|
| UL MUTUAL 142 HERIOT STREET, P.O. Box 696, DRUMMONDVILLE, QUEBEC J2B 6W9 PHONE: 819-478-1315 EXTENSION 2076 - TOLL-FREE: 1-800-567-0988 - FAX: 819-474-1990 |
|--|