Alberta Health and Wellness

AHC0104A

Application for Pre-authorized Payment Plan

Mailing Address
Alberta Health and Wellness
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

Office Address
10025 Jasper Ave Edmonton,
or 727 7 Ave SW, Calgary

Telephone
(780) 427-1432 Edmonton
Toll-free within Alberta at
310-0000 then (780) 427-1432

Fax (780) 422-0102

Website
www.health.gov.ab.ca

Section A - Applicant's personal information

Alberta Health Care Insurance Plan (AHCIP) account number	Applicant's personal health number
	—

Title *(e.g. Mr, Mrs, Miss, Ms, Dr, Rev, Sr)*	Last name

First name	Middle name

Mailing address

City	Province/Territory	Country	Postal code

Home phone number	Work phone number	Extension
( )	( )	

Section B - Applicant's bank account information

Name of financial institution

Branch number	Institution number	Account number

Branch

Branch address

City	Province/Territory	Postal code

For verification, please attach a blank cheque marked "VOID." If you do not have a cheque, please have a representative of your financial institution certify that the bank account information you have provided is correct.

I certify the accuracy of the above branch, institution and account number.

Branch Stamp of Financial Institution

X _____
Signature of financial institution representative

_____
Print name of representative

Section C - Options

a) Receipt of Premium Statements

Premium statements are sent to registrants on a quarterly basis. They specify the amount of premium payable by a registrant (including arrears), as well as information on pre-authorized payment withdrawals, premium rate changes, confirmation of dependant changes and notification of office closures. Your premium statement is your confirmation that payments you have submitted to Alberta Health and Wellness have been processed. **It is the only confirmation of payment that Alberta Health and Wellness issues.**

☐ Please send me Alberta Health and Wellness premium statements.

☐ Please do not send me Alberta Health and Wellness premium statements. Please note: This option is not available to residents whose premium accounts are in arrears.

b) Pre-authorization for Payment of Arrears

You may also use the Pre-authorized Payment Plan to make monthly payments toward arrears. If you wish to use this option, check the box below and indicate the amount you would like to pay in addition to the pre-authorization provided for regular monthly Alberta Health Care Insurance Plan (AHCIP) premiums.

☐ **Yes, I would like to pay my premium arrears by Pre-authorized Payment.**

I authorize Alberta Health and Wellness to withdraw an amount of not more than $ _____ per month from my bank account to pay premium arrears on the AHCIP account identified in Section A. This amount is in addition to amounts that I may have authorized to pay current premiums. This authorization is effective for _____ months, or until all arrears are paid in full, whichever comes first.

(Please indicate # of months)

Section D - Authorization (if more than one account holder, both account holder's names and signatures required)

I acknowledge that I have read and understood the Terms and Conditions of Authorization outlined on the back of this form. I/We authorize Alberta Health and Wellness to automatically withdraw funds from my/our bank account (as indicated above) for payment of AHCIP premiums.

X _____ _____ _____
Signature of bank account holder | Print name | Date

X _____ _____ _____
Signature of bank account co-holder | Print name | Date

Please continue to make premium payments in your usual manner until Alberta Health and Wellness notifies you by mail regarding when the pre-authorized payment withdrawals will commence.

Reset form | Save | Print

TERMS AND CONDITIONS OF AUTHORIZATION

Definitions.

- "AHCIP" means Alberta Health Care Insurance Plan.
- "AHCIP Account" means the premium account including Alberta Blue Cross Non-Group premiums, if applicable, referenced by the AHCIP account number provided in Section A on the front of this form.
- "AHCIP Account Holder" means the individual identified in Section A on the front of this form.
- "AHW" means Alberta Health and Wellness.
- "Authorization" means this Application for Pre-Authorized Payment Plan form.
- "Bank Account" means the account identified in Section B on the front of this form.
- "I," "me" and "my" means each person who signs this Authorization, jointly and severally.
- "PPP" means a Pre-authorized Payment Plan as described in this Authorization.

Scope. I acknowledge that this Authorization is provided for my benefit and the benefit of AHW and my financial institution and is provided in consideration of my financial institution agreeing to process debits against my bank account in accordance with the rules of the Canadian Payments Association.

Valid signing authority. I warrant that all persons whose signatures are required on the bank account have signed Section D on the front of this form.

Authority to debit bank account. I authorize AHW to automatically withdraw funds from my bank account for payment of any current premiums, and, if indicated on the front in Section C, any premium arrears associated with the AHCIP premium account. Each PPP payment will be equal to the monthly premium rate owing on the AHCIP account plus any payment toward arrears authorized in Section C. I understand the PPP will increase or decrease according to the current monthly premium rates billed on my AHCIP account. Notice of changes to monthly premiums can be sent to the address listed on the AHCIP account.

Processing date. PPP transactions will occur on the 15th of each month, or the next business day if the 15th occurs on a weekend or holiday. AHW will send a notice advising of the date the first transaction will occur to the address listed on the AHCIP account.

Change to bank account. I certify that the bank account information I have provided is accurate. I agree to inform AHW, in writing, of any change in my account information at least 21 days prior to the next PPP withdrawal date.

Cancellation by me. I may cancel this Authorization at any time by notifying AHW (at the addresses or telephone numbers listed on the front side of this form) at least 21 days prior to the date of the next PPP withdrawal. Cancellation does not terminate the health care coverage under the AHCIP account, but only affects the method of payment for that coverage.

Cancellation by AHW. I understand AHW may cancel this Authorization immediately, without notice to me, if the PPP withdrawal is returned unpaid by my financial institution for any reason.

Acceptance of delivery of authorization. I acknowledge that providing and delivering this authorization to AHW constitutes delivery by me to my financial institution.

Validation by financial institution. I agree that my financial institution is not required to verify that any PPP has been drawn in accordance with this Authorization, including the amount, frequency and fulfillment of purpose of any PPP.

My dispute rights. I may dispute a PPP if any of the following occurs: (a) the PPP was not drawn in accordance with this Authorization; (b) this Authorization was revoked; or (c) pre-notification of a change to the monthly withdrawal amount was not received. In order to be reimbursed, I acknowledge that a declaration to the effect that either (a),(b) or (c) took place must be completed and presented to the branch of my financial institution where my bank account is located within 90 calendar days after the date the PPP in dispute was posted to my bank account. If I am disputing a PPP after this 90 day period, I will resolve any dispute with AHW.

Collection of information. The information on this Authorization is collected pursuant to section 20 of the *Health Information Act* (as per section 6 of the *Health Insurance Premiums Act*) and section 33 of the *Freedom of Information and Protection of Privacy Act* for the purpose of processing health insurance premium account payments, including arrears, owed to Alberta Health and Wellness. If you have any questions regarding the collection or use of this information, please contact the Client Services Branch at the addresses or telephone numbers listed on the front of this form.

Please retain a copy of this form for your records.