Martin Wright
Insurance & Financial Services Inc.
People you trust ~ Insurance that works!

AS PER PRIVACY STANDARDS, THIS INFORMATION IS FOR UPLOAD PURPOSES ONLY AND WILL BE DESTROYED AFTER PROCESSING.

CREDIT CARD PAYMENT INFORMATION FORM

INSURANCE COMPANY:	**POLICY/BINDER #:**
APPLICANT'S FULL NAME AND POSTAL ADDRESS	**BROKERAGE INFORMATION:**
	Martin & Wright Insurance and Financial Services Inc. 2160 Dunwin Drive, Unit #6 Mississauga, ON L5L 5M8
CONTACT NUMBER(S): TYPE: NO: TYPE: NO: **EMAIL:**	**PHONE NO.:** 905-828-5544 **TOLL FREE:** 1-800-463-4272 **CONTACT:** **CUSTOMER CODE:**

METHOD OF PAYMENT

CREDIT CARD INFORMATION-All credit cards listed below may not be supported by the insurance company. Please refer to your broker and/or company.

TYPE: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

CARD NUMBER:

EXPIRY DATE:	**3-DIGIT SECURITY CODE:**
NAME AS SHOWN ON CARD:	**CARDHOLDER'S SIGNATURE:**

DOWNPAYMENT AMOUNT:	**PAYMENT AMOUNT:**	**FREQUENCY:**
NEXT WITHDRAWAL DATE:	**ADDITIONAL CHARGE(S):** **$** **OR** **%**	**DESCRIPTION OF ADDITIONAL CHARGE(S):**

CONSENT & DISCLOSURE

MY/OUR SIGNATURE CONFIRMS THAT:

1. I/We have been provided with details of and understand the terms and conditions of the payment plan by automatic withdrawals from my/our credit card.
2. I/We understand that this authorization may be cancelled by me/us upon written notice, subject to a period which shall not exceed 30 days. I/We may obtain a sample cancellation form, or further information on my/our right to cancel a payment authorization agreement, at my/our financial institution or by visiting www.cdnpay.ca.
3. I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this payment authorization agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.
4. I/We warrant and guarantee that all persons whose signatures are required to sign on this account have signed the authorization below.

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5. I/We agree that, if there is a change in premium due to a change in coverage, rate, or upon renewal, the amount of the monthly payment will automatically be changed.
6. I/We will ensure that funds are available on each due date and understand that Dishonoured Funds transactions may result in one or all of the following:
    a. A second presentation or attempt to withdraw funds.
    b. A second withdrawal notice.
    c. Cancellation of the policy.
7. I/We agree that, only the insured shall receive written notice from the insurer of the amount to be charged and the due date, at least 10 calendar days prior to the date of the first payment, and any change in the amount or date of the payment.
8. I/We waive the right to obtain written notice from the insurer, of the amount to be debited and the due date(s) of debiting, at least 10 calendar days prior to the date of the payment, even when there is a change in the amount or payment date(s).
9. I/We undertake to inform the insurer, in writing, of any change in the account information provided in this authorization 10 calendar days prior to the next payment due date.
10. I/We understand that this authorization is continuous and will automatically apply to the renewal terms, unless instructed differently.
11. I/We authorize the insurer to collect or use my/our personal information for the purpose of this authorization for automatic withdrawals for payment of the insurance premiums. I/We authorize the insurer to disclose any personal information contained in this authorization form to its financial institution to the extent disclosure is directly related to and necessary for proper execution of the transaction for the policy number noted above.
12. I/We may obtain a copy of or ask questions about the broker's and the insurer's personal information policies by contacting their respective privacy officers.
13. I/We may withdraw my/our consent to collect, use or disclose my/our personal information for the purpose of this authorization for automatic withdrawals for payment of the insurance premiums. Withdrawal of my/our consent will result in cancellation of this authorization for automatic withdrawals for payment of the insurance premiums, in which case the insured must make other arrangements for payment of the insurance premiums.
14. I/We have received a copy of this authorization and have read and understand these terms and conditions.

Please note that a transaction fee may apply to any "Dishonoured Funds".

AUTHORIZED SIGNATURE:	DATE:
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Tel: 904-828-5544 Fax: 905-828-7849
Toll Free: 1-800-463-4272
www.martinandwright.com Email: mail@martinandwright.com