Teamsters Local Union No. 155 Health Benefits Plan

Subsidized Retirement Plan ("SRP") Pre-Authorized Debit Agreement

To set up pre-authorized debit payments, please complete and sign this PAD Agreement and attach a void cheque or banking information form from your financial institution. This form authorizes Teamsters Local Union No. 155 Health Benefits Plan to debit your account.

1. PAYOR'S INFORMATION

Name: _____ PBC ID No.: _____

Address: _____

Street City Province Postal Code

Telephone: _____ Email: _____

Type of Service (check one): ☑ Personal ☐ Business

2. PAYMENT INFORMATION

Current Rates effective Jan 1, 2026 (check one): ☐ **Single** ($153.00 per month) ☐ **Couple** ($272.00 per month)

Debited on the 15th of each month (or next business day); amount subject to change in accordance with the PAD Agreement below.

3. BANKING INFORMATION

Attach VOID cheque or official banking information form from your financial institution.

4. SIGNATURES AND AUTHORIZATION

a. By signing this form, I/we authorize Teamsters Local Union No. 155 Health Benefits Plan ("the Trust") and the financial institution designated (or any other financial institution I/we may authorize at any time) to debit my/our account for monthly recurring payments required under the Subsidized Retirement Plan ("SRP").

b. I/We agree that the monthly premium required under the SRP, as determined by coverage category and as amended from time to time by the Trustees, will be debited from my/our specified account on the 15th day of each month (or the next business day if the 15th falls on a non-business day). The Trust may adjust the PAD amount to reflect any approved rate change upon providing at least ten (10) business days' prior written notice. No further authorization will be required for such adjustments.

c. The Trust will obtain my/our authorization for any one-time or sporadic debits not contemplated under this Agreement.

d. This authorization shall remain in effect until the Trust has received written notification of its cancellation by mail, email, or fax at least ten (10) business days before the next scheduled debit. I/We may obtain a sample cancellation form or further information regarding my/our right to cancel a PAD Agreement from my/our financial institution or by visiting www.payments.ca.

e. PAD withdrawals will continue in accordance with this Agreement until cancellation is processed or until I/we are no longer eligible for SRP coverage.

f. I/We acknowledge that the information contained in this Agreement may be shared with the financial institution(s) as necessary to complete any PAD transaction.

g. The Trust may not assign this authorization, whether directly or indirectly, without providing at least ten (10) days' prior written notice to me/us.

h. 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 PAD that is not authorized or is not consistent with this Agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.payments.ca.

i. I/We agree that I/we are fully liable for any charges incurred if a debit cannot be completed due to insufficient funds or any other reason for which I/we may be held responsible.

The undersigned hereby authorizes the execution of the above.

_____ _____ _____ _____

Client Signature Date Client Signature Date

Note: If only one signature is required for the account, then only that individual needs to sign; however, if two or more signatures are required on the account, both or all must sign.

Administrator: Convyta 501-4445 Lougheed Hwy Burnaby BC V5C 0E4

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