THE HEALTH SPENDING ACCOUNT PLUS PLAN

How The Plan Works

- Estimate your family's expected medical and dental expenses for the next year. A detailed list of eligible expenses is included in the Participation Agreement which accompanies this application.
    - Include in your estimate: repeat prescription drug expenses, regular dental check-ups, orthodontics or dental implants, eye glasses, contact lenses, or laser eye surgery, chiropractic and massage therapy expenses, and any other expected medical or dental expenses.
- Minimum annual contribution $3,000 for you and your family.
- Divide the expected annual expenses by 12 to determine your monthly funding requirement (minimum $250 per month). You may want to add a margin for unexpected expenses.
- Deposit the first month's contribution plus the appropriate taxes and administration charges into your specific trust account, which is maintained and administered by The Benefits Trust. A worksheet is included with this package.
- On-going monthly contributions will be automatically withdrawn from your bank account. A pre-authorized payment form is included with this application.
- Claim against your trust account for reimbursement as you and your family incur medical and dental expenses.
- You can add a separate Health Care Spending Account for each employee (if applicable), with an annual amount that meets your budget. No minimum is required for employees.

Taxation

- 100% of the deposits into the Health Spending Account Plus Plan, including administration and applicable taxes, are tax deductible business expenses. This includes deposits for both you and your employees.
- All benefits received are non-taxable to the individual.

Administration Fee per Health Care Spending Account

- 15.0% administration fee per year charged on HCSA contribution amount
- Plus applicable taxes (Ontario):
  2.0% premium tax charged on HCSA contribution and administration
  8.0% provincial insurance tax charged on HCSA, and insurance premiums
  13.0% HST charged on administration fee and premium tax

Please contact our office with any questions about applicable taxes in other provinces.

THE HEALTH SPENDING ACCOUNT PLUS PLAN

Catastrophic Event Insurance Protection

Out of Country Emergency Medical Care

- Insurance coverage for reasonable and customary charges in the area where the emergency occurred, in the event of a sudden, unexpected illness or injury during the first 60 days of travel for business or pleasure. This plan includes hospital care, physician's services, and other appropriate standard medical treatment.
- Maximum $5,000,000 per covered person in their lifetime.
- Supplementary Travel Assist Services are provided for personal or medical emergencies.
- Underwritten by RSA Travel Insurance Inc.
- For employees age 70 and over: Six month Pre-Existing Condition stability clause.

Excess Medical Stop Loss Insurance

- Supplemental Insurance protection for catastrophic in-Canada Health Care claims in excess of $5,000 per person per year. Coverage includes Semi-private hospital room, Private Duty Nursing and Prescription Drugs. This plan also covers each person for recurring treatments.
- A standard 12/24 month pre-existing conditions clause applies to all participants in this plan.
- Maximum $1,000,000 per covered person in their lifetime.
- Underwritten by RSA Travel Insurance Inc.

Monthly Premium for Catastrophic Event Insurance Protection

Includes both Out of Country Emergency Medical Care and Excess Medical Stop Loss Insurance:

	Under Age 70	Age 70 to 79
Single:	$21.15 per month	$35.35 per month
Family:	$42.30 per month	$70.70 per month

Prices valid from January 1, 2016 until December 31, 2016.

Health Spending Account Plus Benefits Plan

Monthly Premium Calculation Worksheet

Section A: Pooled Benefits

Excess Medical Stop Loss Insurance	$ 5,000
Out of Country Emergency Medical Insurance	60 days

Pooled Benefits Premiums

	Monthly rate	x	# Employees	= Monthly Premium
Single per month	**$18.55**	x	_____	= _____
Family per month	**$37.10**	x	_____	= _____

A: Total Pooled per Month _____

Section B: Health Care Spending Accounts

Amount as determined by the plan sponsor

	Annual amount	/ 12 =	Monthly amount	x	# Employees	= Monthly Contribution
Class A	_____	/ 12 =	_____	x	_____	= _____
Class B	_____	/ 12 =	_____	x	_____	= _____
Class C	_____	/ 12 =	_____	x	_____	= _____

Total HCSA per Month _____

Administration Fee 15% of HCSA Contributions Total HCSA per Month x 15% = _____

B: Total HCSA & Admin per Month _____

Calculating the Deposit

Step 1	Total Pooled per Month	A		_____
Step 2	Total HCSA & Admin per Month	B		_____
Step 3	**Total Pooled + Total HCSA & Admin**	(A + B)	**Deposit**	_____

* Applicable provincial sales taxes and HST will be applied to monthly invoices

Make your deposit cheque payable to The Benefits Trust.

Future monthly contributions will be automatically withdrawn from your bank account.

HEALTH SPENDING ACCOUNT PLUS PLAN
Enrollment Form

Corporate Information

Company Name

_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____ Email: _____

Personal Information

˜ Mr. ˜ Mrs.

Last Name: _____ First Name: _____ ˜ Ms. ˜ Miss

Address: _____ Apt. # _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (Month) _____ (Day) _____ (Year) _____ S.I.N. : _____ - _____ - _____

Sex: ˜ M ˜ F

Marital Status: ˜ Single ˜ Married ˜ Separated ˜ Divorced ˜ Common Law ˜ Length of C/L Relationship: _____

Dependant Information

Please list all dependants including your spouse, common-law spouse (relationship of at least one year), and/or children. Children are eligible if under age 21, or under age 26 and attending school full time, or disabled and completely dependent on you for support. Complete an "**Overage Dependant**" form if applicable.

			Date of Birth		
Spouse's Last Name	First Name		**(Month)**	**(Day)**	**(Year)**
_____	_____	˜ M ˜ F	_____ /	_____ /	_____
Child's Last Name	First Name		**(Month)**	**(Day)**	**(Year)**
1. _____	_____	˜ M ˜ F	_____ /	_____ /	_____
2. _____	_____	˜ M ˜ F	_____ /	_____ /	_____
3. _____	_____	˜ M ˜ F	_____ /	_____ /	_____
4. _____	_____	˜ M ˜ F	_____ /	_____ /	_____

Selection of Coverage

Annual HCSA: _____ Benefit Year Beginning: (Month) _____ (Day) 01 (Year) _____

Member's Authorization

I hereby apply for the benefits for which I am or may become eligible, subject to any waiver indicated, under the Participation Agreement issued by The Benefits Trust and authorize that any required contributions be deducted from my earnings. In addition, I authorize The Benefits Trust and its administrators to use my social insurance number, if applicable, for identification purposes in the administration of the benefits plan. On behalf of myself and my dependents, I also authorize The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Enrollment and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Participation Agreement issued by The Benefits Trust. I have not received tax advice from The Benefits Trust, it administrators, or any of its agents.

Member's Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____

Claims Direct Deposit Authorization Form
(Electronic Funds Transfer)

You may choose to have claims payments from The Benefits Trust deposited directly to your bank account. Explanations of benefits will be sent by email to the address provided on this form. **Please print clearly.** To set up this convenient process, complete this form and return it with a "void" cheque to The Benefits Trust.

Employee Information

Employee Name (as shown for banking purposes):

_____

Employee Email: _____

Employer Name: _____

Contract or Group No: _____ Certificate No: _____

Attach "void" cheque

I authorize The Benefits Trust to deposit all future claims payments directly to the account shown on the attached "void" cheque. I understand that any change to this authorization must be submitted in writing.

Signature: _____ Date: _____

Return the completed form by mail, email, or fax with a "void" cheque. Please contact our office with questions.

The Benefits Trust
3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9

Phone: 905-264-8990
Toll Free: 800-487-2993

Fax: 905-264-1123
Email: claims@thebenefitstrust.com

For internal use only

EFT Processed: _____

Application Checklist

Submission Guidelines

Minimum $3,000 in annual HCSA funding for participating member. No minimum funding requirement for employees (if applicable).

Member (and eligible employees if any) must work a minimum of 20 hours per week.

Complete applications received at The Benefits Trust on or before the 15th of the month will take effect the first of the following month.

NOTE: Incomplete applications will not be processed until all materials are received at The Benefits Trust.

The following materials are enclosed (√) with this submission:

❑ Premium Calculation Worksheet and Premium Deposit for $ _____

❑ Enrollment Forms for member & eligible employees. Number enclosed: _____

❑ Participation Agreement, completed and signed by member.

❑ Pre-Authorized Payment (PAP) Form with void cheque.

Rather than send in a binder cheque, you may authorize The Benefits Trust to take the deposit by PAP. Advisor or client initial for authorization: _____

The Benefits Trust
3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9
416-498-7723 or 905-264-8990
www.thebenefitstrust.com

Broker / Agent Information and Declaration

Name of Client: _____

Broker / Agent Name: _____

Title: _____

Broker / Agent Corporate Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____

Email: _____

Agent Signature: _____ Date: _____

For internal use only

Agent Number: _____

Broker EFT Received:

_____

PARTICIPATION AGREEMENT

between

THE BENEFITS TRUST (the "Trust")
3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9

and

CONTRACTHOLDER _____
(Legal company name – please print clearly)

Address _____

City _____ Prov _____ Postal Code _____

Effective the first day of (month) _____ , (year) _____

The purpose of this document is to outline the terms and conditions of the financial accounting arrangements with respect to benefits provided by the Trust to the employees of the Contractholder.

INSURED BENEFITS

Nature of Benefits

The insured benefits consist of excess medical stop loss insurance, out of country emergency medical insurance and travel assistance benefits.

Underwriter

The insured benefits are provided through group insurance policies issued by the life insurance companies (the "Insurers") selected by the Trust and shown in Appendix A.

Insured Arrangements

Insured arrangements are described in the group insurance policies and underwriting agreements issued by the Insurer.

Payment of Premiums

The Insurer in consultation with the Trust sets premium rates. Premiums for insured benefits are paid monthly by the Contractholder to the Trust, through automatic withdrawal in accordance with the pre-authorized payment form which accompanies this agreement. The Trust remits premiums to the Insurer on behalf of the Contractholder.

Renewal

In addition to any terms or conditions contained in the group policies of underwriting agreements, premiums may be adjusted on any renewal date as described in Appendix A.

Termination of Coverage

In addition to any terms or conditions contained in the group policies or underwriting agreements, insured benefits may be terminated without further notice to the Contract-holder or its employees, in the event that any required contribution is not received by the Trust within 31 days of the due date, and until all outstanding contributions are paid in full.

HEALTH CARE SPENDING ACCOUNT BENEFITS

Nature of Benefits

The benefits consist of a health care spending account as described in Appendix B and the Enrollment Form forming part of this agreement between the Trust and the Contractholder. The Health Care Spending Account benefits are administered by the Trust and funded by the Contractholder.

Neither the Trust nor its agents underwrite or insure any Health Care Spending Account benefits provided to the Contractholder or its employees.

Payment of Contributions for Health Care Spending Account (HCSA)

Contributions in respect of the Health Care Spending Account are paid monthly by the Contractholder to the Trust, through automatic withdrawal in accordance with the pre-authorized payment form which accompanies this agreement.

Financial Arrangements for Health Care Spending Account (HCSA)

The Contractholder is required to pay the monthly contribution. The monthly contribution amount equals:

One-twelfth (1/12) of the annual amount of the Health Care Spending Account according to the attached Enrollment Form forming part of this agreement, per contract year per employee,
plus Plan Operation Costs calculated in accordance with Appendix C,
plus applicable provincial or federal sales tax, and provincial premium tax.

The benefit plan outlined in this agreement is designated as a Funded plan for the purposes of Ontario Retail Sales Tax (ORST).

The Contractholder is responsible for the entire Health Care Spending Account amount for each employee in each contract year, regardless of the termination date of the employee. Claims will reimbursed up to a maximum of the annual Health Care Spending Account amount for each employee. Claims may be reimbursed up to the level of available funding at the time of claim at the discretion of the Trust. The Health Care Spending Account amount for a new employee whose coverage is effective during the contract year will be eligible for a pro-rated amount based on the number of full months worked in the contract year.

Carry Forward Provision

Balance Carry Forward: Any unused funds in each employee's HCSA at the end of each contract year may be carried forward to the following contract year. Claim expenses may not be carried forward. Any carry-forward funds that are not spent by the employee by the end of the second contract year are returned to the Contractholder.

Renewal

A renewal calculation is due on:

i) the date described in Appendix C,
ii) every date on which the Contract is materially amended,
iii) any other date mutually agreed by the Trust and the Contractholder.

Delinquent Contributions

In the event any required contribution is not received by the Trust within 31 days of the due date, claim payments may be suspended without further notice to the Contractholder or its employees until all outstanding contributions are paid in full.

Termination of Contract

This Participation Agreement may be terminated by the Contractholder or by the Trustees upon thirty-one (31) days written notice.

In the event of the termination of the Contract for any reason,

i) any deficit previously identified, and
ii) the full monthly contribution amount for the month of termination become immediately payable in full.
iii) Any surplus previously identified will be refunded to the Contractholder.

Unless specific arrangements are made to the contrary, the Trust will not be liable for any claims or other expenses incurred or submitted after the date of termination.

Not more than ninety days after the Trust ceases to be liable to pay any claims or other expenses on behalf of the Contractholder, the Trust will prepare a final accounting statement. Any surplus or deficit so identified will be refunded to the Contractholder or paid to the Trust, as the case may be, within thirty one days of the delivery of such statement to the Contractholder.

Adequacy of Records

The Trust will rely on any information provided by the Contractholder in order to calculate the amount of any payment. The Contractholder is liable for any error resulting from incorrect or incomplete data supplied to the Trust.

For The Benefits Trust:	For the Contractholder:
_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Date	Date

APPENDIX A

Insured Benefits

The following insured benefits are provided by the noted insurers. For details of these insured benefits, refer to the group insurance policies.

Benefit	
Excess Medical Stop Loss Insurance including Semi-Private Hospital Coverage	RSA Travel Insurance Inc.
Out of Country Emergency Medical Insurance with Travel Assist Services	RSA Travel Insurance Inc.

Renewal Date

The policy renewal date is set as twelve months from the effective date of this Agreement, and every 12 month period thereafter.

APPENDIX B

Guidelines For Claim Expenses Eligibility

Whose Claims Are Considered Eligible?

The Employee may submit claims for eligible expenses which are incurred by themself, their spouse, or any other dependent for whom the employee is claiming a tax deduction in the taxation year the expense was incurred.

What Expenses Are Considered Eligible?

Eligible expenses include:

- Expenses listed as eligible medical expenses in the Income Tax Act, its regulations and Interpretation Bulletins (see following list). This list is subject to change as the Act is amended.
- Unpaid portions of expenses from regular health and dental plans such as deductibles, co-insurance amounts and amounts which exceed plan maximums;
- Expenses not covered under any other benefit plan (group, provincial, or private);

Eligible Expenses under the Income Tax Act

Medical Practitioners (if registered in the province where the expenses occurred)

- Chiropodists or Podiatrists
- Chiropractors
- Christian Science Nurses
- Christian Science Practitioners
- Dentists
- Massage Therapists
- Medical Doctors
- Naturopaths
- Nurses
- Occupational Therapists
- Optometrists, Oculists, or Ophthalmologists
- Osteopaths
- Physiotherapists
- Psychologists
- Speech Therapists
- Therapists or Therapeutists

Care and Facilities

- Expenses of a full-time attendant, or of full-time care in a nursing home, for an individual who has a severe and prolonged mental or physical impairment. The condition must be certified by a medical doctor or optometrist, where applicable.
- Expenses of a full-time attendant, if an individual lives in a self-contained domestic establishment (e.g., the individual's home), provided a doctor certifies that the individual is likely to be dependent others for personal needs and care for an indefinite period because of a mental or physical infirmity.
- Expenses of full-time care in a nursing home for an individual who, due to a lack of normal mental capacity, is and will continue to be dependent upon others for personal needs and care. The certification of a doctor is required to support the need for this care.
- Expenses for the care and/or training at a school, institution or other place (e.g., nursing home) when an individual has been certified to be someone who, because of a physical or mental impairment, requires the equipment, facilities or personnel provided by such place. An appropriately qualified person must certify that the individual's condition requires such care.
- Expenses of a public or licensed private hospital, including hospitals outside Canada.

Assistance Devices, Supplies, and Equipment

- Eyeglasses or other devices for the treatment or correction of a defect in vision
- Artificial eyes and limbs
- Crutches
- Wheelchairs
- Walkers
- Spinal brace/support
- Brace for a limb
- Iron lung/portable chest respirator
- Rocking bed for poliomyelitis victims
- Ileostomy or colostomy pads
- Cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by an individual who is incontinent by reason of illness, injury, or infliction
- Truss for a hernia
- Artificial kidney machine
- Laryngeal speaking aid
- Aids to hearing
- Device or equipment, including replacement parts, designed exclusively for use by an individual suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, but not including an air conditioner, humidifier, dehumidifier, or air cleaner

Assistance Devices, Supplies, and Equipment (continued)

- Air or water filter or purifier for use by an individual who is suffering from a severe chronic respiratory ailment, or a severe chronic immune system disregulation, to cope with or overcome the ailments disregulation
- Electric or sealed combustion furnace acquired to replace a furnace which is neither, where the replacement is necessary solely because of a severe chronic respiratory ailment or a severe chronic immune system disregulation
- Device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease
- Device that is designed to assist an individual with mobility impairment in walking
- Device designed exclusively to enable an individual with a mobility impairment to operate a motor vehicle
- Power-operated guided chair installation that is designed to be used solely in a stairway
- Mechanical device or equipment designed to assist an individual to enter or leave a bathtub or shower or to get on or off a toilet
- Power-operated lift designed exclusively for use by a disabled individual to allow access to different areas of a building or to assist the individual to gain access to a vehicle or to place the individual's wheelchair in or on a vehicle
- Electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction
- External breast prosthesis that is required because of a mastectomy
- Hospital beds, including any necessary attachments prescribed for an individual
- Oxygen tent or equipment necessary to administer the oxygen (includes the oxygen)
- Custom made wig for an individual who has suffered abnormal hair loss as a result of disease, medical treatment or an accident
- Device designed to be attached to an infant diagnosed as being prone to Sudden Infant Death Syndrome in order to sound an alarm if the infant ceases to breathe
- Extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema
- Inductive coupling osteogenesis stimulator for treating non-union of a fracture or aiding in bone fusion
- Infusion pump, including disposable peripherals, used in the treatment of diabetes, or a device designed to enable a diabetic to measure blood sugar levels
- Needles and syringes for injections
- Orthopaedic shoe or boot, or an insert for a shoe or boot, custom made for an individual in accordance with a prescription to overcome a disability
- Device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer
- Optical scanner or similar device designed to enable a blind individual to read print

Assistance Devices, Supplies, and Equipment (continued)

- Device to decode special television signals to permit the vocal portion of the signal to be visually displayed
- A visual or vibratory signaling device, including a visual fire alarm indicator, for an individual who has a hearing impairment
- Electronic speech synthesizer that enables a mute individual to communicate by using a portable keyboard

Drugs

- Insulin
- Vitamin B12 and liver extract indictable for pernicious anaemia
- Drugs, medications or other preparations or substances prescribed by a medical practitioner or dentist and recorded by a pharmacist

Transportation, Meals, and Accomodation

- Expenses for transportation by ambulance to or from a public or licensed private hospital
- Transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if medically necessary, as certified by a medical practitioner) provided:
  - Substantially equivalent medical services are not available locally
  - The route taken is reasonable direct
  - The medical treatment sought is reasonable and the distance traveled is at least 40 kilometres

    If hired transportation is not readily available, reasonable expenses for private transportation will be eligible.
- Reasonable expenses for meals and accommodation for a patient and, if medically required, an accompanying person, provided the conditions for transportation expenses (specified above) are satisfied and the distance traveled is at least 80 kilometres

Dental

- Preventive, diagnostic, restorative, orthodontic, and therapeutic care
- Making or repairing of dentures by a licensed dental mechanic

Other Expenses

- Diagnostic, laboratory, and radiological procedures or services for maintaining health and preventing disease, or assisting in the diagnosis or treatment of an injury, illness or disability of an individual, when prescribed by a doctor or dentist
- Acupuncture treatment when performed by a qualified medical doctor
- Reasonable expenses for rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for an individual's loss of hearing or speech
- Reasonable expenses for modifications to a home for an individual who lacks normal physical development, or who has severe and prolonged mobility impairment, so as to enable the individual to gain access and move around the home
- On behalf of an individual who requires a bone marrow or organ transplant:
- Reasonable expenses to locate a compatible donor and arrange for the transplant
- Reasonable traveling, board and lodging expenses of the donor and the individual with respect to the transplant
- The cost of acquisition, care and maintenance (including food and veterinarian care) of an animal if the animal is specifically trained to assist an individual who is blind, profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of the arms or legs. In addition, reasonable traveling, board, and lodging expenses incurred while in full-time attendance at a facility that trains individuals in the handling of such animals are eligible.

APPENDIX C

Plan Operation Costs

Costs payable by the Contractholder are shown in item (i) below, and include, but are not limited to, claims adjudication, claims payment, employee record keeping, plan and claim enquiries, and plan accounting, plan reporting, and benefit administration.

(i) Health Care Spending Account

15.0% of Contractholder contributions

Renewal Date

The contract renewal date is set as twelve months from the effective date of this Agreement, and every 12 month period thereafter.

PAYOR'S AUTHORIZATION FOR PRE-AUTHORIZED DEBITS FOR BUSINESS PURPOSES

1. Payor's Name and Address – please print

   We warrant and represent that the following information is accurate.

Company Name		
Street		
Town	Postal Code	Telephone No.

Name of Payor's Financial Institution (the "Processing Institution")			
Street			Town
Postal Code	Bank No.	Transit No.	Account No.

   We have attached a specimen cheque marked "VOID" to this payor authorization (the "Authorization").

   We will inform the Payee, in writing, of any change in the information provided in this section of the Authorization prior to the next due date of the PAD.

2. Payee's Name and Address – please print

Name of Payee (the "Payee") The Benefits Trust		
Street: 3800 Steeles Avenue West, Suite #102W		
Town: Vaughan, Ontario	Postal Code: L4L 4G9	Tel: (905) 264-8990

3. We acknowledge that the Authorization is provided for the benefit of the Payee and the Processing Institution and is provided in consideration of the Processing Institution agreeing to process debits against our account, as listed above, (the "Account") in accordance with the Rules of the Canadian Payments Association.

4. We warrant and guarantee that all persons whose signatures are required to authorize withdrawals from the Account have signed the Authorization and that all persons signing this Authorization are our authorized signing officers and are empowered to enter into this agreement.

5. We hereby authorize the Payee to issue Pre-Authorized Debits (as defined in Rule H4 of the Rules of the Canadian Payments Association) (the "PAD") drawn on the Account, for the following purpose:
   - payment of group employee benefit plan.

6. We may cancel the Authorization at any time upon providing written notice to the Payee.

7. We acknowledge that provision and delivery of the Authorization to the Payee constitutes delivery by us to the Processing Institution. Any delivery of the Authorization to the Payee, regardless of the method of delivery, constitutes delivery by us.

8. Unless otherwise agreed to in writing, the Payee will provide to us, at the address provided in Section 1:

   a) with respect to fixed amount PADs, written notice of the amount to be debited (the "Payment Amount") and the date(s) on which the Payment Amount debited will be posted to our Account (the "Payment Date"), at least 10 calendar days before the Payment Date of the first PAD, and such notice shall be provided every time there is a change in the Payment Amount or the Payment Date(s);

   b) with respect to variable amount PADs, written notice of the Payment Amount and the Payment Date(s), at least 10 calendar days before the Payment Date of every PAD; and

   c) with respect to a PAD plan that provides for the issuance of a PAD in response to a direct action of ours (such as, but not limited to, a telephone instruction) requesting the Payee to issue a PAD in full or partial payment of a billing received by us for a payment obligation that meets the requirements of Section 2 or Rule H4, no notice is required.

9. The Payee may issue a PAD monthly in a dollar amount as presented to the Payor and may vary with usage and taxes.

10. We acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of the Authorization including, but not limited to, the amount, or that any purpose of payment for which the PAD was issued has been fulfilled by the Payee as a condition to honouring a PAD issued by the Payee on the Account.

11. Revocation of the Authorization does not terminate any contract for goods or services that exists between us and the Payee. The Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.

12. We may dispute a PAD only under the following conditions:
    (i) the PAD was not drawn in accordance with the Authorization;
    (ii) the Authorization was revoked; or
    (iii) pre-notification, as required under Section 8 was not received.

    We acknowledge that in order to be reimbursed a declaration to the effect that either (i), (ii) or (iii) took place, must be completed and presented to the branch of the Processing Institution holding the Account up to and including 10 business days after the date on which the PAD in dispute was posted to the Account.

    We acknowledge that when disputing any PAD beyond the time allowed in this section, it is a matter to be resolved solely between us and the Payee, outside the payment system.

13. We agree that the information contained in the Authorization may be disclosed to the Payee's Financial Institution as required to complete any PAD transaction.

14. We understand and accept the terms of participating in this PAD plan.

_____
(COMPANY NAME)

_____
(AUTHORIZED SIGNATURE)

_____
(AUTHORIZED SIGNATURE)