CENTRE DE SANTÉ DE LA VALLÉE MASSAWIPPI

PRE-AUTHORIZED DEBIT AGREEMENT
PAYOR'S PAD AGREEMENT

Account holder name and account number

Last and first name(s) of account holder(s)			Telephone No.
Address (street, city, province)			Postal code
The name of the financial institution where the account is located	Institution No.	Transit No.	Account No. (with check digit)

Payee – Contact information

Name of organization CENTRE DE SANTÉ DE LA VALLÉE MASSAWIPPI	c/o or e-mail address information@csvm.ca	
Address (street, city, province) 1082 MAIN STREET, AYER'S CLIFF, QUÉBEC	Postal code J0B 1C0	Telephone No. (819) 838-1082

Withdrawal authorization

I, the undersigned, (if a legal person, herein represented by its duly authorized representative(s)), authorize the Payee to make pre-authorized debits (PAD) from my account with the aforementioned financial institution, at the following interval:

☐ monthly

☐ other(please specify the time or event that defines the interval) _____

Each withdrawal will correspond to:

☐ a variable amount, of which I must be advised by the Payee in writing at least 10 days before the due date.

☐ a fixed amount of $_____, which may be increased without any further authorization on my part, provided that the Payee notifies me in writing at least 10 days before the due date of the payment as modified:

for the following service: _____

which together constitutes a ☐ personal/individual PAD ☐ business PAD

Waiver:

☐ **I hereby waive the aforementioned written notice of 10 days.**

☐ **I have received a copy of this Agreement and waive all other confirmation before the first payment.**

Change or cancellation:

I shall inform the Payee, in a timely manner, of any changes to this Agreement.

I retain the right to revoke my authorization at any time, with a pre-notification of _____days (maximum 30 calendar days). To obtain a sample of the cancellation form or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit the Payments Canada Web site at www.payments.ca. I agree to release the financial institution of any liability if the revocation is not respected, except in the case of gross negligence on its part.

I agree that the financial institution at which I maintain the account is not required to verify that the payment is debited in accordance with this authorization. I also certify that every person whose signature is required for the operation of the aforementioned account has signed this authorization.

I acknowledge that the delivery of this authorization to the Payee constitutes delivery by me to the aforementioned financial institution.

Reimbursement

I have certain rights of recourse if a debit does not comply with the terms of this Agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or that is not compatible with the terms of this PAD Agreement. For more information on my rights of recourse, I may contact my financial institution or visit www.payments.ca.

The financial institution shall reimburse me, on behalf of the organization, for any amounts withdrawn in error, within 90 calendar days of the withdrawal for a **Personal** PAD and within 10 business days for a **Business** PAD, provided that the reimbursement is claimed for a valid reason.

I understand that a claim to this effect must be made to my financial institution following the procedure it will provide for that purpose.

Finally, I acknowledge that a claim for reimbursement filed after the aforementioned time limits must be settled between me and Payee, without any liability or commitment on the part of my financial institution.

Consent to disclosure of information

I hereby consent to the disclosure of the information contained in my pre-authorized debit enrolment agreement to the financial institution, provided such information is directly related to and required for the smooth application of the rules governing pre-authorized debits.

Signature of account holder (s)

_____ _____
Signature of account holder — Date (dd/mm/yyyy)

_____ _____
Signature of a second account holder (Only if two signatures are required) — Date (dd/mm/yyyy)

IMPORTANT: Attach a personal **cheque marked "VOID"** to avoid errors in transcription. If you change your account or financial institution, please advise the payee organization.