

Pre-Authorized Debit (PAD) Agreement

South and Central Health Foundation

Date: _____

I want to support the South and Central Health Foundation through automatic monthly donations directly from my bank account.

Please debit my bank account: *(Please attach a Void cheque)*

_____ \$25 _____ \$50 _____ \$75 **Other Amount** _____ **(Specify)**

The debit will be processed to your account on the 18th day of each month or the next business day.

Signature:

Donor Name:

Address/Contact Information:

This donation is made on behalf of: an Individual _____ a Business _____

I may revoke my authorization at any time, subject to providing notice of 30 days. To obtain a sample cancellation form, or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit www.cdnpay.ca.

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P.O. Box 739
Grand Falls-Windsor, NL A2A 2K2
Tel: (709) 292-2360 Fax: (709) 292-2193
E-mail: schf@centralhealth.nl.ca

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

