



PRE-AUTHORIZED DEBIT ENROLLMENT

Account holder(s) and contact information

Name and surname of the holder(s)		Phone number	
Address (street, city, province)		Postal code	
Name of the financial institution where the account is held	Institution number	Transit number	Account number (with check digit)

Beneficiary organization-Contact information

Name of the organization	E-mail
Les Amis de la Saint-Camille	info@amis-st-camille.org
Address	Phone
381 Raoul, Saint-Colomban, Québec, J5K 2C4	450-675-8290

Authorization for withdrawal

I, the undersigned, authorize Les Amis de la Saint-Camille to make pre-authorized monthly debits of a fixed amount to help fulfill its mission.
 Each withdrawal will correspond to a fixed amount of _____ on date _____ of each month.

Waiver:
 I acknowledge receipt of a copy of this agreement and waive any further confirmation prior to the first payment.

Change or cancellation:
 I will notify the Recipient Organization within a reasonable time of any changes to this Agreement.
 I may revoke my authorization at any time upon 7 days notice.
 I agree that the financial institution where I have my account is not required to verify that the payment is drawn in accordance with my authorization. I further certify that all persons whose signatures are required for the operation of the account identified above have signed this authorization.
 I acknowledge that delivery of this authorization to the payee is equivalent to delivery to the financial institution indicated above.

Refunds and consent to release information

<p>I have certain recourse rights if a debit does not comply with this Agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. For more information on my recourse, I may contact my financial institution or visit www.cdnpay.ca.</p>
<p>I consent to the release of the information contained in this pre-authorized debit application to the financial institution.</p>

Signature of the holder(s)

_____ Account holder signature	_____ Date (mm/dd/yyyy)
_____ Signature of second holder <small>(if it is an account for which two signatures are required)</small>	_____ Date (mm/dd/yyyy)

Important : To avoid transcription errors, attach a personal check marked <CANCELLED> if possible. If you change your account or financial institution please notify Les Amis de la Saint-Camille.

To send by mail or for any questions regarding the follow-up of your monthly pre-authorized debit, please contact the treasurer of Les Amis de la Saint-Camille at 256 Boulevard De La Rochelle, Repentigny, (Québec) J6A 1K9 Telephone: 514-774-3421.