

**Pre-authorized Debit (PAD) Agreement**

Date: \_\_\_\_\_

I want to support the Norfolk Pregnancy & Family Resource Centre (NPC) through monthly donations.

**Please debit my bank account**

\$25  \$50  \$75  \$100  Other amount \_\_\_\_\_

*(amount indicated will be processed to your account on the 18th day of each month or the next business day)*

**Bank Information:** (attach void cheque or fill out information below)

**Account #** \_\_\_\_\_ **Branch/Transit #** \_\_\_\_\_

**Financial Institution #** \_\_\_\_\_ **Account type:**  Chequing  Savings

**Financial Institution's name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Donor information:**  personal donation  business donation

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

I understand that I may revoke my authorization at any time, subject to providing notice to the NPC in writing within 30 days of desire to cancel. To obtain a 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](http://www.cdnpay.ca).

**Signatures: of account holder(s)**

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(signature)

**Donation to: Norfolk Pregnancy Centre**

37 Robinson Street

Simcoe, ON N3Y 1W5

P: 519-428-2177 E: [director@norfolkpc.org](mailto:director@norfolkpc.org)

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](http://www.cdnpay.ca)