



Pre-authorized Debit (PAD) Agreement

1. CUSTOMER INFORMATION (please print)

Name

Mailing Address

City

Province

Postal Code

() _____
Mobile Phone Number

() _____
Home Phone Number

() _____
Work Phone Number

Email Address

2. ACCOUNT HOLDER INFORMATION (complete if different than above)

Name

Mailing Address

City

Province

Postal Code

() _____
Mobile Phone Number

() _____
Home Phone Number

() _____
Work Phone Number

Email Address

3. ACCOUNT INFORMATION

Please attach a personalized cheque marked VOID or a Pre-authorized Debit Form completed by your financial institution.

4. CONSENT & AGREEMENT

- I/we authorize The Compassion Network Inc. to debit the bank account identified above (or any other financial institution I/we, the Account Holder(s), may authorize at anytime) for monthly regular recurring payments and/or one time payments for all charges arising under my/our The Compassion Network Inc. account. Regular monthly payments for the full amount of services delivered and fees incurred will be debited on the third business day of each month. If funds are not available on this date, the debit will be represented twenty (20) days later. I/we authorize The Compassion Network Inc. to present multiple payments and/or to change the amount of the debit as a result of my/our direct action (such as, but not limited to, a telephone instruction or other remote means), as required to maintain my/our services. I/we will be charged an administrative fee for declined debits. I/we agree that The Compassion Network Inc. is not responsible for any bank service charges relating to declined debits. **I/we have waived my/our right to receive pre-notification of the amount of the PAD and agreed that I/we do not require advance notice of the amount of PADs before the debit is processed.**
- I/we would like a copy of the invoice or receipt sent to the email mailing address indicated under Account Holder Information above.
- These services are for (check one) Personal Business
- I/we may revoke my authorization at any time by submitting written notice to The Compassion Network Inc. at least ten (10) business days before the next debit date. To obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement, I/we may contact my financial institution or visit www.cdnpay.ca.

Signature of Account Holder

Name (please print)

Date

Signature of Joint Account Holder (if applicable)

Name (please print)

Date

- I/we have certain recourse rights if any debit presented by The Compassion Network Inc. does not comply with this agreement. For example, I/we 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/our recourse rights, I/we may contact my financial institution or visit www.cdnpay.ca.

5. SUBMIT THE COMPLETED FORM TO

The Compassion Network Inc.
PO Box 67035
Edmonton AB T5R 5Y3
Fax: 780-756-8145
Email: info@compassionnetwork.ca