



4. Pre-Authorized Debit (PAD) Details

I/We authorize (**MOUNTED POLICE PROFESSIONAL ASSOCIATION**) and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our (**MOUNTED POLICE PROFESSIONAL ASSOCIATION**) account(s). Regular monthly payments for the full amount of services delivered will be debited to my/our specified account on the ____ day of each month. These services are for (**enter reason**).

These services are for (check one) ____ personal or ____ business purposes.

MOUNTED POLICE PROFESSIONAL ASSOCIATION will obtain my/our authorization for any other one-time or sporadic debits and provide me with 10 calendar days written notice prior to any debits. This authority is to remain in effect until **MOUNTED POLICE PROFESSIONAL ASSOCIATION** has received written notification from me/us of its change or termination. This notification must be received at least thirty 30 calendar days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

In the case of variable amount PADs, **MOUNTED POLICE PROFESSIONAL ASSOCIATION** will provide 10 days written notice prior to any changes in the fees and/or its schedule.

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

I/We understand and accept the terms of participating in this PAD plan.

Signature of Account Holder

Signature of Joint Account Holder (if appropriate)

Name (Please print)

Name (Please print)

Date

Date

When the form is complete, submit to:

P.O. BOX 76004 FAX: 1 (855) 530-4720
LANGLEY, B.C.
V1M 4B7