GRACE HOSPITAL
FOUNDATION

Pre-Authorized Debit Agreement

Please complete the information below. You may also provide a void cheque that contains this information.

Donor Name

Home Address **Unit/Apt. #**

City/Prov. **Postal Code**

Email **Phone**

Name of Financial Institution

Account #

Transit # **Financial Institution #**

I authorize the Grace Hospital Foundation and the financial institution named above (or indicated on the void cheque I have provided) to withdraw $ from my account for personal monthly recurring donations. This authority is to remain in effect until Grace Hospital Foundation has received notification from me of its change or termination. I agree to provide the Grace Hospital Foundation with a minimum of 10 days advance notice prior to my debit for processing any changes inclusive of cancellation.

I acknowledge that I have certain recourse rights that I can follow 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 your recourse rights, please contact your financial institution or visit www.cdnpay.ca.

I warrant and guarantee that all persons whose signatures are required to sign to debit this account have been provided. I waive the right to receive pre-notification of the amount to be debited each month under this agreement. If I do not agree with any of the terms and conditions described above, need to make any changes, or cancel my donation, I will contact Grace Hospital Foundation immediately by calling 204-837-0375 or visiting www.gracehospitalfoundation.ca/contact.

X _____

Donor Signature & Date