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MONTHLY DONATION VIA PRE-AUTHORIZED CREDIT CARD or DEBIT PAYMENT
PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

I would like to support the ongoing provision of free services for individuals affected by cancer. I would like to offer this support through a monthly donation.

1. Personal Information *(please print clearly)*

First Name: _____ Last Name: _____
First Name: _____ Last Name: _____
Street Address: _____
City: _____ Province: _____ Postal Code: _____
Telephone: _____ E-mail: _____
Would you like to receive CAP's twice yearly newsletters? ◯ YES ◯ NO

2. Credit Card Information

I (we) authorize the Cancer Assistance Program to process a payment in the amount of $ _____ on my (our) credit card on the _____1st or _____15th of each month (or the next business day), commencing in the month of _____ 20_____.

◯ $10 ◯ $25 ◯ $50 ◯ $75 ◯ $100 ◯ Other amount (specify): _____

◯ Mastercard ◯ VISA
Name(s) on card: _____
Card Number: _____/_____/_____ Expiry Date*: _____/_____
Signature: _____ Date: _____
Signature: Date:

**please note that this form will require renewal upon the expiry and renewal of any credit card on file*

3. Bank/Debit Information

I (we) authorize the Cancer Assistance Program to process a debit in the amount of $ _____ on my (our) account on the _____ 1st or _____ 15th of each month (or the next business day), commencing in the month of _____ 20_____.

◯ $10 ◯ $25 ◯ $50 ◯ $75 ◯ $100 ◯ Other amount (specify): _____

I have attached a VOID cheque as required by the bank for pre-authorized transactions: ◯ Yes
◯ Chequing Account ◯ Savings Account Account Number: _____
Bank Transit Number: _____ Financial Institution Number: _____
Financial Institution Name: _____ Branch Address: _____
City: _____ Postal Code: _____
Signature: _____ Date: _____
Signature: Date:

4. Donation Designation

I (we) wish to have my (our) monthly donations designated:
◯ at CAP's discretion ◯ to the Drive & Ride program ◯ to _____

You have certain recourse rights if any charge/debit does not comply with this PAD Agreement. For example, you have the right to receive reimbursement for any charge/debit that is not authorized or is not consistent with this Agreement. To obtain more information on your rights contact your financial institution or visit www.cdnpay.ca. You may revoke authorization of this Agreement at any time, subject to providing a completed cancellation form 10 business days prior to the next scheduled payment. To make inquiries, obtain a cancellation form or seek further recourse, please contact Alana Travis, Donations Administrator, at 905.383.9797 ext. 101 or by e-mailing atravis@cancerassist.ca or by mailing or attending 569 Concession Street, Hamilton, ON L8V 1B2. The cancellation form can also be found at www.cancerassist.ca/donate-now. An official tax receipt will be issued to you for your donations. Monthly donors will receive one receipt following the completion of the calendar year for the full amount of their annual donations. **Charitable Registration #14026 2759 RR0001.**