Ontario Chiropractic Association

PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

Return the completed form with a specimen cheque marked "VOID" (for the Account described below) to the Ontario Chiropractic Association.

MEMBER INFORMATION

Name:

Address:

City/Province: Postal Code:

Phone: ( ) Fax: ( ) Email Address:

ACCOUNT INFORMATION

Bank or Financial Institution:

Address:

City/Province: Postal Code:

Account Number:

Branch Number: Institution Number:

AUTHORIZATION

I agree to participate in this pre-authorized debit plan and I authorize the Ontario Chiropractic Association (OCA) to debit the account indicated above (or such other replacement account as I indicated on a new void specimen cheque provided by me to you) ("Account") on the first of every month or the next business day from my Account for payment of regular monthly OCA and Canadian Chiropractic Association Membership Dues. All persons whose signatures are required to debit the Account have signed this authorization.

This service is for (check one) ( ) Personal ( ) Business

I may revoke this Authorization at any time, subject to providing notification at least ten (10) business days before the next debit is scheduled by delivering a written notice of revocation to the Ontario Chiropractic Association. To obtain a sample 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.

I will inform the Ontario Chiropractic Association, in writing, of any change in the Account information provided in this Authorization ten (10) business days prior to the next due date of the Pre-Authorized Debit.

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.

I waive the right to receive 10 days pre-notification prior to my first debit and any changes to the amount of each PAD if due to changes in the applicable tax rate or other adjustment.

My Signature (Account-Holder) ***Date***

Second authorized signatory on the Account (if any) ***Date***

200 – 20 Victoria St., Toronto ON M5C 2N8 1-877-DCS-CARE(327-2273) (416) 860-0070 fax (416) 860-0857