

Ontario Health Coalition

Medicare Supporters Monthly Giving Plan and Regular Membership

If you have already donated this year, please accept our warm thanks and please ignore this form

Organization (if applicable) _____

Contact Name: _____

Mailing Address: _____

City/Town: _____ Postal Code: _____

Phone: (H) _____ (W) _____

Fax: _____ Email: _____

PLEASE JOIN OUR MONTHLY GIVING

Under this plan, a set amount will be withdrawn directly from your account each month as a personal donation to the Ontario Health Coalition.

YES! I will give per month a fixed amount monthly:
(circle one) \$5 \$10 \$20 other _____

Every 1st or 15th of the month (circle one).
Starting date: _____, 2010

Please attach a blank voided cheque.

If only 1 signature is required for the account, then only 1 Payor need sign. If 2 or more signatures are required, then both or all Payors must sign.

I/We authorize the Ontario Health Coalition to debit my account with the financial institution noted on my cheque for the amount and frequency described above until written notice to the contrary is given.

Payor signature(s):

Date:

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 the PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca

This Authorization may be cancelled at any time upon notice being provided by me either in writing or orally, with proper authorization to verify my identity within 10 days before the next PAD is to be issued. I acknowledge that I can obtain a sample cancellation form or further information on my right to cancel this Agreement from the Ontario Health Coalition or by visiting www.cdnpay.ca

PLEASE DON'T MISS THE BACK !



CAN'T GIVE MONTHLY? ANNUAL MEMBERSHIP FEES 2010

Individual members: \$20

Organizations:

Under 100 members: \$25

Over 100 members, membership rates set at \$0.20 per member, e.g:

500 members = \$100
1,000 members = \$200
5,000 members = \$1,000
10,000 members = \$2,000 etc.

Your membership fee rate enclosed is \$ _____

Additional donation (circle one):

\$20 \$50 \$100 \$200 \$500 \$1000

Is this a membership renewal? (check one)

Yes No Not Sure

Please fill out this form and send it to us at:

**Ontario Health Coalition
15 Gervais Drive, Suite 305
Toronto, Ontario M3C 1Y8**

Phone: 416-441-2502 Fax: 416-441-4073
E-mail: ohc@sympatico.ca

Check us out online at: www.ontariohealthcoalition.ca

Ontario Health Coalition

15 Gervais Drive, Suite 305, Toronto, Ontario M3C 1Y8

Terms and Conditions

1. In this Agreement, "I", "me" and "my" refers to each Account Holder whose signature appears.
2. I authorize the Payee, in accordance with the terms of my account agreement with my Financial Institution, to debit or cause to be debited the Account for the purposes indicated in this agreement.
3. Particulars of the account the Payee is authorized to debit are indicated in the Account details section of this agreement. A specimen cheque, if available for the Account, has been marked "VOID" and attached to this Authorization.
4. I undertake to inform the Payee, in writing, of any change in the Account information provided in this Authorization, 10 days prior to the next due date of the PAD.
5. Revocation of this Authorization does not terminate any contract for goods or services that exist between the Ontario Health Coalition and me. This authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.
6. I acknowledge that provision and any delivery of this Authorization to the Payee constitutes delivery by me to my Financial Institution.
7. Unless I have waived any and all requirements for pre-notification of debiting in the Waiver of Pre-Notification section of this Agreement, I acknowledge that I will receive written notice of the amount and payment date from the Payee at least 10 calendar days prior to the payment date:
 - a. For the first PAD when the amount is fixed for a Business or Personal PAD.
 - b. Anytime there is a change in the amount or payment date when the amount is fixed for a Business or Personal PAD.
 - c. For every PAD when the amount is variable and is a Business or Personal PAD.
 - d. For any change in the amount resulting from an increase in any applicable tax rate, a top-up or any other adjustment for a Business, Personal or Funds Transferred PAD.
8. If this Authorization provides for PADs with sporadic frequency, I understand the Payee is required to obtain an authorization from me for each and every PAD prior to the PAD being exchanged and cleared. I agree that a password or security code or other signature equivalent will be issued and will constitute valid authorization for my Financial Institution to debit the Account.
9. I agree that my Financial Institution is not required to verify that any Personal PAD has been drawn in accordance with the Agreement, including the amount, frequency and fulfillment of any purpose of any Personal PAD.
10. I acknowledge that, if this Authorization is for personal or business PADs, or for funds transfer PADs that I have recourse through the clearing system, a PAD may be disputed but only under the following conditions:
 - a. The PAD was not drawn in accordance with this Authorization/
 - b. This Authorization was revoked, or
 - c. Pre-notification was required and was not received.
11. I further agree that in order to be reimbursed, a declaration to the effect that either (a), (b), or (c) took place must be completed and presented to the branch of my Financial Institution holding the Account on or before the 90th calendar day in the case of a personal PAD or a funds transfer PAD that has recourse through the clearing system or, in the case of a business PAD, on or before the 10th business day, in each case after the date on which the PAD in dispute was posted to the Account.
12. I acknowledge that any claim made after the periods set out above must be resolved solely between me and the Payee and there is no entitlement to reimbursement from my Financial Institution.
13. I agree that if this Authorization is for funds transfer PADs and the Payee does not provide recourse through the clearing system, then no recourse will be provided through the clearing system (that is, I will not receive automatic reimbursement or recourse from the Payee in the event a PAD is erroneously charged to the Account).
14. I understand that I am participating in a PAD plan established by the Payee, I accept participation in the PAD plan upon the terms, and conditions set out herein.
15. I consent to the disclosure of any personal information that may be contained in the Authorization to the Financial Institution that holds the account of the Payee to be credited with the PAD to the extent that such disclosure of personal information is directly related to and necessary for the proper application of Rule H1 of the Rules of the Canadian Payments Association.