



Donation type: General *In Memoriam* In honour Other (specify) _____

SINGLE DONATION

Single donation amount:

\$100 \$75 \$50 \$25 Other: \$
Specify

MONTHLY DONATION

Monthly donation amount:

\$50 \$20 \$10 \$5 Other: \$
Specify

ⓘ Please fill the preauthorized debit agreement on the back

Payment method:

To reduce our administrative costs as much as possible, we propose making the deduction from your banking account instead of charging the amount to your credit card. This way, we would not have to pay fees to financial institutions.

I've enclosed a **cheque** made payable to the Canadian Cancer Society.

I've enclosed a **blank cheque** marked VOID. I authorize the Canadian Cancer Society to deduct the amount I have specified from the account number on the cheque, on the 15th day of each month.

Please charge to my **credit card**

I authorize the Canadian Cancer Society to charge the amount specified above to my **credit card** on the 15th day of each month:

Credit card information

VISA MasterCard AmericanExpress

Name on the card: _____

Card number: _____

Expiry date: ____ / ____ (YY/MM)

Signature: _____

Donor information for tax receipt

French English / Mr. Ms.

First name: _____ Last name: _____

Address: _____

City: _____ Province: _____

Postal Code: _____ Phone*: _____

Email: _____

For statistic purposes only, could you indicate the birth year of the donor?

** to contact the donor in case of a problem with the credit card.*

For a group donation, we need the name and address of all donors to issue personal receipts.

Information for the In Memoriam or In Honour card

Language of the card: French English

Name of card recipient: _____

Address of card recipient: _____

City: _____ Province: _____

Postal Code: _____ Country: _____

From (you can sign the card as an individual or as a group):

Please write the text you would like to appear on the card (optional):

The donor's address to appear on the card*: Yes No

** so the family can thank you.*

Name of the deceased or honoured person:

All donations of \$10 or more will be receipted automatically; others on request. Charitable registration No. 118829803 RR0007 (Can.) 98-6001242 (U.S.A.)

Send this form by fax (514 255-2808) or regular mail at your regional office or at this address:

**Canadian Cancer Society
Quebec Division
5151 de l'Assomption Blvd.
Montreal (Quebec) H1T 4A9**

**1 888 939-3333
cancer.ca**



Pre-Authorized debit agreement Payor's pad agreement

Account holder name and account number

| | | | |
|--|-----------------|---------------|--------------------------------|
| Last and first name(s) of account holder(s) | | Telephone No. | |
| Address (street, city, province) | | Postal code | |
| The name of the financial institution where the account is located | Institution No. | Transit No. | Account No. (with check digit) |

Payee – Contact information

| | | |
|---|--|---------------------------------|
| Name of organization Canadian Cancer Society | c/o or e-mail address dons@quebec.cancer.ca | |
| Address (street, city, province) 5151, de l'Assomption Blvd., Montreal, Quebec | Postal code H1T 4A9 | Telephone No. 1 888 939-3333 |

Withdrawal authorization

I, the undersigned, (if a legal person, herein represented by its duly authorized representative(s)), authorize the Canadian Cancer Society (CCS) to deduct the fixed amount I have specified on the back of this form from the account number on the cheque, on the 15th day of each month.

This constitutes a personal PAD business PAD

Waiver:

I hereby waive the written notice confirming changes to this debit.

I have received a copy of this Agreement and waive all other confirmation before the first payment.

Change or cancellation:

I shall inform the Payee, in a timely manner, of any changes to this Agreement.

I retain the right to revoke my authorization at any time, with a pre-notification of 30 calendar days. To obtain a sample of the cancellation form or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit the Canadian Payments Association Web site at www.cdnipay.ca. I agree to release the financial institution of any liability if the revocation is not respected, except in the case of gross negligence on its part.

I agree that the financial institution at which I maintain the account is not required to verify that the payment is debited in accordance with this authorization. I also certify that every person whose signature is required for the operation of the aforementioned account has signed this authorization.

I acknowledge that the delivery of this authorization to the Payee constitutes delivery by me to the aforementioned financial institution.

Reimbursement

I have certain rights of recourse if a debit does not comply with the terms of this Agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or that is not compatible with the terms of this PAD Agreement. For more information on my rights of recourse, I may contact my financial institution or visit www.cdnipay.ca.

The financial institution shall reimburse me, on behalf of the organization, for any amounts withdrawn in error, within 90 calendar days of the withdrawal for a **Personal** PAD and within 10 business days for a **Business** PAD, provided that the reimbursement is claimed for a valid reason.

I understand that a claim to this effect must be made to my financial institution following the procedure it will provide for that purpose.

Finally, I acknowledge that a claim for reimbursement filed after the aforementioned time limits must be settled between me and Payee, without any liability or commitment on the part of my financial institution.

Consent to disclosure of information

I hereby consent to the disclosure of the information contained in my pre-authorized debit enrolment agreement to the financial institution, provided such information is directly related to and required for the smooth application of the rules governing pre-authorized debits.

Signature of account holder (s)

| | |
|--|----------------------------|
| _____ Signature of account holder | _____ Date (dd/mm/yyyy) |
| _____ Signature of a second account holder (Only if two signatures are required) | _____ Date (dd/mm/yyyy) |

IMPORTANT: Attach a personal cheque marked "VOID" to avoid errors in transcription. If you change your account or financial institution, please advise the payee organization.