Pre-Authorized Debit (PAD) Agreement

Customer Information *(please print clearly)*		
Full Name:		
Company Name:		
Billing Account Number/Customer Code:		
Mailing Address:		
City:	**Province:**	**Postal Code:**
Telephone No:	**Email:**	
These services are for: *(please check one)*	**Personal** ☐	**Business use** ☐

Pre-Authorized Debit (PAD) details *(please print clearly)*		
Financial Institution:		
Branch Address:		
City:	**Province:**	
Postal Code:	**Telephone No:**	
Bank Number : *(3 digits)* ☐☐☐	**Transit Number:** *(5 digits)* ☐☐☐☐☐	
Account Number:		

Please attach a voided copy of your cheque with your account number micro encoded on the bottom

I/we authorize TELUS Health to begin deductions for monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our TELUS Health account(s). Regular monthly payments for the full amount indicated on the monthly premium billing statement will be debited from my/our specified account on the 4th day of each month. TELUS Health will obtain my/our authorization for any other one-time or sporadic debits.

Please ensure your Financial Institution is advised in advance of the regular monthly recurring payments. Many institutions will require notification from you prior to the first withdrawal in order to avoid declined payments on suspicion of fraudulent charges.

I/we acknowledge that any NSF fees will be my/our responsibility if payment is declined for any reason.
I/we will notify TELUS Health promptly in writing if I/we move the account from one bank or branch to another, or if there is any other changes in the account.

I/we may revoke this authorization at any time, subject to providing notice to TELUS Health. This notification must be received at least thirty (30) business days before the next debit is scheduled at the address below. I/we understand that if I/we cancel this authorization, it does not mean that our contract obligations to the Company are ended. For more information on my right to cancel a PAD agreement or obtain a sample cancellation form, I/we may visit: www.cdnpay.ca.
I/we are authorized to sign on behalf of the above account.

_____ _____

Date Authorized Signature(s)

_____

Name/s (please print)

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we 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/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Please return the completed form to:

csc@telushealth.com
Fax: 1-877-464-0109