PRE-AUTHORIZED DEBIT AGREEMENT
PAYEE AUTHORIZATION

Account holder name and account number

Last and first name(s) of Account Holder(s)			NBASW Member #
Email Address			Telephone number
Address (Street, City, Province)			Postal code
The name of the financial institution where the account is located	Institution number	Transit number	Account number (include void cheque)

Payee organization – Contact information

Name of organization New Brunswick Association of Social Workers	e-mail address info@nbasw-attsnb.ca	
Address (Street, City, Province) PO Box 1533 Stn A, Fredericton, NB	Postal code E3B 5G2	Telephone number (877) 495-5595

Authorisation of withdrawal

I, the undersigned, (if a legal person, herein represented by its representative(s), who declare themselves duly authorized for the purposes hereof), authorize the payee organization to make pre-authorized debits (PAD) from my account with the financial institution indicated above, at the following interval:

☐ **Monthly** for a withdrawal period of six (6) months, September through February each year.

Each withdrawal will correspond to: *(select one)*

☐ **Practicing Membership:** a fixed amount of **$71.50** that may be decreased or increased without other authorization on my part, as long as the payee organization forwards me a written notice at least 10 days before the expected deadline of the payment as modified; **OR**

☐ **Non-Practicing Membership:** a fixed amount of **$21.00** that may be decreased or increased without other authorization on my part, as long as payee organization forwards me a written notice at least 10 days before the expected deadline of the payment as modified:

for the following service: Annual NBASW membership dues.

❑ **Waiver:**

❑ **I hereby waive the written notice of 10 days mentioned above. *(required)***

❑ **I have received a copy of this Agreement and waive all other confirmation before the first payment. *(required)***

Change or cancellation:
I shall inform the payee organization, in a timely manner, of any changes to this Agreement.

I may revoke my authorization at any time, with a notice of 30 days. To obtain a copy of my cancellation form or for more information on my right to cancel a PAD Agreement, I may consult with my financial institution or visit the Canadian Payments Association Web site at www.cdnpay.ca. I agree to release the financial institution of all liability if the revocation is not respected, except in the case of gross negligence by the financial institution.

I agree that the financial institution with which I have my account is not responsible for verifying that the payment is debited in accordance with my authorization. I also confirm that all the people whose signatures are necessary for the operation of the account mentioned above have signed this authorization. I am aware that by submitting the present authorization to the payee organization, I am also submitting it 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 consult with my financial institution or visit www.cdnpay.ca.

The financial institution will 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, insofar as the reimbursement is requested for an acceptable reason.

I understand that these types of requests are to be made to my financial institution following the procedure it will provide me.

Finally, I acknowledge that a request for reimbursement submitted after the deadlines previously indicated must be settled between the organization and me, with no responsibility or engagement on the part of the financial institution.

Consent for disclosure of information

I agree that the information in my application for pre-auhorized debit authorization will be shared with the financial institution, insofar as the the disclosure of this information is directly related to and necessary for the proper application of the rules applicable for pre-authorized debits.

Signature of account holder (s)

_____
Name (please print)

_____ _____
Signature of account holder — Date

_____
Name (please print)

_____ _____
Signature of a second account holder (Only if two signatures are required) — Date

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.