



PRE-AUTHORIZED DEBIT (PAD) AGREEMENT

I/we authorize Amity Home Care Ltd. and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin deductions as per my/our instructions for weekly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our Amity Home Care Ltd. account(s). Regular weekly payments for the full amount of services delivered will be debited to my/our specified account on Monday of each week. Amity Home Care Ltd. will obtain my/our authorization for any other one-time or sporadic debits.

Frequency and Amount Of Debits: A debit, in paper, electronic or other form in the amount of \$ _____ or a variable amount, with a reasonable latitude for adjustments and in no case to exceed \$ _____, may be drawn on my/our specified account _____ (frequency: Weekly/Monthly/Bi-monthly/sporadic) beginning _____. Annual top-ups or adjustments are/not permitted. If payments are sporadic, I/we agree to cooperate with the Payor to pre-authorize the processing of each and every PAD against my/our account whether authorized verbally or electronically, by use of a password, secret code or such other signature equivalent, as the parties shall agree to constitute valid authorization.

Pre-Notification Waiver: I/We agree with the Payee to waive the requirement under the CPA Rules to receive a written pre-notification prior to each PAD as set out in the Rules.

Payor Signature:		Payor Signature:	
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This authority is to remain in effect until Amity Home Care Ltd. has received written notification from me/us if its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

Amity Home Care Ltd. may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us.

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 and PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Please enter your information on next page, sign and return to Amity Home Care Ltd. at your earliest convenience.



CUSTOMER INFORMATION (Please Print Clearly)			Date:	
Name(s):			Account Number:	
		Type of Service:	<input type="checkbox"/> Personal	<input type="checkbox"/> Business
Address:				
City/Town:		Province:		Postal Code:
Phone Number (Bus):		Phone Number (Res):		
Financial Institution (FI):				
FI Account Number:		FI Transit Number:	_____	FI Number:

Address:				
City/Town:		Province:		Postal Code:
Authorized Signature(s):				

Please attach a copy of a void cheque to:

Amity Home Care Ltd.

Suite 300, 4838 Richard Road SW

Calgary, Alberta T3E 6L1

Bus: 587-997-7565

E-Mail: general@amityhomecare.ca