PREAUTHORIZED DEBIT AGREEMENT (PAD)

Reset Form

Name: _____ Employee #_____

Primary Phone_____ Personal Email: _____

You, the payor, hereby authorize Markham Stouffville Hospital, the payee, to deduct the required amounts so as to continue coverage of your benefits until such time you return to work or are no longer eligible to purchase these benefits**.** You understand pre-authorized debit will use the same account as the current pay deposit account.

Conditions of the preauthorized debit agreement

- You will be notified in writing if your preauthorized payment will be different than what is currently deducted from your earnings (i.e. What appears on your pay stub)
- Debits to your account will occur monthly on the first business day of the month. The actual date of withdrawal may depend on your financial institution.
- Debits rejected due to non-sufficient funds will again be debited on the 15th day of the same month, or the next closest business day. If that debit is again rejected, benefit **coverage will be cancelled**. Once benefits are cancelled they cannot be reinstated.
- A $40 administration fee will be charged by the Hospital in the case of non-sufficient payments
- The Hospital will use your personal email address as stated above to inform you of changes to benefit costs and debit amounts.
- You must inform the Hospital in writing of any changes to banking information at least 30 days before a payment is due.
- To revoke this authorization, you must provide at least 30 days written notice to the Hospital.

You have certain recourse rights if any debit does not comply with this agreement. For example, you 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 your recourse rights, contact your financial institution or visit www.cdnpay.ca.

Questions can be directed to Human Resources
HumanResourcesInquiries@msh.on.ca

EMPLOYEE SIGNATURE: _____ **DATE:** _____

MARKHAM STOUFFVILLE HOSPITAL CORPORATION