Saskatchewan Health Authority

LONG TERM CARE PREAUTHORIZED DEBIT (PAD) AGREEMENT

Please complete the Pre-Authorized Debit (PAD) Plan agreement below.

I/We authorize Saskatchewan Health Authority (SHA), and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions for the full amount of payment due for long stay charges, rent and supplies by the undersigned to Saskatchewan Health Authority. Regular monthly payments will be withdrawn from my/our specified account within the first 5 days of the month.

By signing this form, you have waived your right to receive pre-notification of the amount of the PAD and agreed that you do not require advance notice of the amount of PADs before the debit is processed.

This authority is to remain in effect until the Saskatchewan Health Authority has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next withdrawal 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.payments.ca.

Saskatchewan Health Authority may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least ten (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 any 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.payments.ca.

PLEASE PRINT

Resident Name:_____

Saskatchewan Health Authority Account Number: _____

PAD Authorized by:

Name(s): _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: (Primary) _____ (Alt.) _____

Please select applicable services:

☐ Receivables (Rent & Supplies)

☐ Trust/comfort fund maintain minimum balance of $_____

Authorized Signature(s): _____ **DATE:** _____

ATTACH VOID CHEQUE OR BANK PRE-AUTHORIZED DEPOSIT/DEBIT FORM

Return with: Move-In Agreement
OR
Email to SHAAffiliatesAR@saskhealthauthority.ca