



# "Friends Forever" Monthly Giving Program

I/We, \_\_\_\_\_ want to make giving easy! I/we would like to join the "Friends Forever" Monthly Giving Program with my/our monthly gift of:

\$10       \$15       \$25      Other \$ \_\_\_\_\_

**Credit card and pre-authorized debit gifts are processed on the 15<sup>th</sup> of each month.**

You the Donor authorize **Sault Area Hospital Foundation** to begin deductions as per my/our instructions for monthly regular recurring payments for a charitable donation.

*Donor Information:*

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*Payment Preference Information:*

- Post Dated Cheques  
Please make cheque payable to: Sault Area Hospital Foundation (or SAHF)
- I/We wish to contribute through: \_\_\_\_\_ Visa \_\_\_\_\_ MasterCard

Card Number: \_\_\_\_\_ Expiry: \_\_\_\_\_

- Pre-authorized Debit Payment  
I/We have enclosed a cheque marked 'VOID'

**Bank Account Information (attach void cheque)**

Financial Institution Account: \_\_\_\_\_ F.I. Transit \_\_\_\_\_  
Financial Institution: Name: \_\_\_\_\_  
Address: \_\_\_\_\_

These services are for (check one) \_\_\_\_\_ personal \_\_\_\_\_ business use

Regular monthly payments in the amount of \$\_\_\_\_\_ will be debited to my/our specified account on the 15<sup>th</sup> of each month or first following business day. This authority is to remain in effect until **Sault Area Hospital Foundation** has received written notification from me/us of its change or termination. This notification must be received at least 10 business days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or for more information on my/our right to cancel a PAD Agreement, contact your financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

Authorized Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

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 my recourse rights, you may contact my financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca).

**Sault Area Hospital Foundation**  
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Sault Area Hospital Foundation respects your privacy. We protect your personal information and adhere to all legislative requirements with respect to protecting privacy. We do not rent, sell or trade our mailing lists. The information you provide will be used to deliver services and to keep you informed and up to date on the fundraising activities of the Foundation. If at any time you wish to be removed from our mailing list, simply contact us by phone at (705) 759-3848 or via e-mail at [foundation@sah.on.ca](mailto:foundation@sah.on.ca) and we will gladly accommodate your request.