



Pre-Authorized Debit (PAD) Plan agreement

1. Payment Information

* Monthly Debit Amount: \$ _____

* Transaction Date: From: ____/____/____ To: child's Termination Date OR To: ____/____/____
mm dd yyyy mm dd yyyy

1. NEW PARENTS: Please attach a VOID CHEQUE

2. CURRENT PARENTS: You agree to use same VOID CHEQUE on file YES: _____

2. Pre-Authorized Debit (PAD) Details

I / We authorize **SSP 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 monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our SSP account (s). Regular monthly payments for the full amount of services delivered will be debited to my/our specified account on the **1st day of each month.**

SSP LTD will obtain my / our authorization for any other one-time or sporadic debits and will provide me / us with 10 calendar days written notice of the amount prior to any debits.

This authority is to remain in effect until **SSP LTD** has received written notification from me / us of its change or termination. This notification must be received at **least sixty (60) calendar days** before the next debit is scheduled at the address provided below. I / We may revoke this authorization at any time, subject to providing two months written notice. 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.

I / We agree that should my payment not clear for any reason; the PAD will re-try within 5 days and a **\$50 NSF fee** will be charged for this service.

In the case that I / We request a change in service I / We agree that **SSP LTD** automatically update the PAD amount upon receiving authorization in writing or email. 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.cdnpay.ca.

I / We understand and accept the terms of participating. In this PAD plan.

Signature of Account Holder

Signature of Account Holder

Name (Please Print)

Name (Please Print)

Date

Date

Phone Number

Phone Number

Type of Service: Personal _____ Business _____

Please submit completed form to:

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seedlingsspanish@gmail.com