Interior Health

Preauthorized Payment Plan

Client Name	Facility/Community

Financial Contact

Name *(Last, First, Middle Initial)*

Mailing Address *(Street, City, Province, PC)*

Program ***(Please check all that apply)***

☐ Adult Day ☐ Waiting for Long Term Care Placement ☐ Home Support ☐ Lifeline

☐ Meals on Wheels ☐ Long Term Care Accommodations / Comforts ☐ Other _____

Please select the purpose for completing this form:

☐ Initial Enrollment ☐ Change of Financial Institution *(Branch or Account)* ☐ Cancellation

I (we) hereby authorize the Interior Health Authority and the Financial Institute designated on this form to debit my (our) account at the indicated branch under the terms and conditions agreed to by me (us) with the Interior Health Authority.

The branch of the Financial Institution at which I (we) maintain the account is not required to verify that the payment is drawn in accordance with the authorization.

A debit, in paper, electronic or other form may be drawn on my (our) account within 5 – 10 business days from the 1st of the month. This will begin the month of _____ .

Monthly payments to equal amounts as invoiced for selected programs.

Monthly payments to comfort accounts (if applicable) (please check √) ☐ pay in full monthly ☐ amount $ _____

I (we) will notify the Interior Health Authority in writing of any changes in the account information or termination of the authorization prior to the next due date of the pre-authorized debit.

Items charged will be reimbursed subject to notification by me (us) to the branch of account within 90 days under any of the following conditions:

(a) I (we) never provided the authorization to the Payee.
(b) The pre-authorized debit was not drawn in accordance with this authorization.
(c) My (our) authorization was revoked.
(d) The debit was posted to the wrong account due to invalid/incorrect information supplied by the Interior Health Authority.

I (we) understand that a written declaration to this effect must be given to my (our) financial institution and acknowledge that delivery of this authorization to the Interior Health Authority constitutes delivery by me (us).

Signature	Date (dd/mm/yyyy)

Staple **Blank Void Cheque** here **OR** have your financial institution complete the following:

Name of Financial Institution		Address *(Street, City, Provice, PC)*
Branch Number	**Financial Institution Number**	**Account Number**