

# SCHEDULE "A" to POLICY GGS-14



Mail / Fax / Email to: **RM of St. Andrews**  
 Box 130  
 Clandeboye, MB R0C 0P0  
 Ph.: 204-738-2264  
 Fax: 204-738-2500  
 becky@rmofstandrews.com

**ROLL NO:**

## PRE - AUTHORIZED DEBIT FORM FOR TIPPS

☐ **ENROLLMENT**    ☐ **CHANGE** (Please only complete information to be changed)

☐ **CANCELLATION**    effective as of: \_\_\_\_\_

### Customer Information:

Name:		
Mailing Address:		
City:	Province:	Postal Code:
Home Phone: (    )	Business Phone: (    )	Email:

### Payments are to be debited from the following account:

Financial Institution Name:		Financial Institution Address:	
City:	Province:	Postal Code:	Phone: (    )
PAD Frequency:		Amount:	
Banking Information:			
Bank ID	Transit No	Bank Account No	

**- Be sure to include a Void Cheque or Deposit Slip -**

### Authorization:

I/We hereby request and authorize CAFT (Payment Processor) on behalf of the RM of St. Andrews to debit payments and service charges authorized by me/us from the chequing account specified by me. Notice of cancellation of this authorization may be made by me/us by the 15th of any month, <b>in writing</b> . Such notice shall not have effect on debits made prior to cancellation.	
<b>** NOTE:</b> If funds are not available, a NSF charge of \$50.00 will be applied. If three payments have been returned as NSF, your privileges to use these services will be canceled and you will no longer be eligible to enroll in this program for a period of 12 months.	
Customer Name: _____	Customer Name: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

**\*\* The RM of St. Andrews warrants that it will maintain all information confidential and will use it exclusively for the purposes of affecting the payment services of CAFT. Personal information collected on this form is protected by *The Freedom of Information and Protection of Privacy Act* will be used only to respond to this request.**