save your skin FOUNDATION LA FONDATION sauve ta peau

DONATION FORM
DATE: ____/_____/_____

Donation type: General / *In Memoriam* / In honour / Other (specify) _____

SINGLE DONATION

Single donation amount:

$100 / $75 / $50 / $25 / Other (specify): $_____

MONTHLY DONATION

Monthly donation amount:

$50 / $20 / $10 / $5 / Other (specify): $_____

Please fill out the preauthorized debit agreement

Payment method:

To reduce our administrative costs, we propose making the monthly deduction from your bank account instead of having to pay financial institutions to charge the amount to your credit card.

☐ I have **enclosed a cheque** made payable to the Save Your Skin Foundation

☐ I have enclosed a **blank cheque** marked VOID. I authorize the Save Your Skin Foundation to deduct the amount I have specified from the account number on the cheque, on the 15th day of each month

☐ Please charge to my **credit card**

☐ I authorize the Save Your Skin Foundation to charge the amount specified above to my **credit card** on the 15th day of each month

Credit card information

VISA / MasterCard / AmericanExpress

Name on the card: _____
Card number: _____
Expiry date:___/___(YY/MM) CVV Number:_____
Signature: _____

Donor information for tax receipt

English / French Mr. / Ms.
First name:_____Last name: _____
Address:_____
City:_____Province:_____
Postal code:_____Phone*:_____
Email: _____

** to contact the donor in case of a problem with the credit card*

For a group donation, we need the name and address of all donors to issue personal receipts.

Information for the *In Memoriam* or In Honour Card

Language of the card: English / French
Name of card recipient: _____
Address of card recipient: _____

City:_____Province:_____
Postal Code:_____Country:_____
From (can be an individual or group): _____
Please write any text you would like to appear on the card:

Name of the deceased or honoured person: _____

_____

All donations of $10 or more will be receipted automatically; others on request. Charitable registration No. 857756589RR0001 (Can.)

Send this form by regular mail to:
Save Your Skin Foundation
319-3600 Windcrest Drive
North Vancouver, BC, V7G 2S5
Canada

www.saveyourskin.ca
604-842-5658

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PRE-AUTHORIZED DEBIT AGREEMENT

Account holder name and account number:

Last and first name(s) of account holder(s): Telephone No.:

Address (street, city, province, postal code):

Financial Institution | Institution No. | Transit No. | Account No. (with cheque digit)

Payee- Contact information

Name of Organization	c/o or email address
Save Your Skin Foundation	kathy@saveyourskin.ca
Address (street, city, province, postal code)	Telephone No.
319-3600 Windcrest Dr., North Vancouver, BC, V7G 2S5	604-842-5658

Withdrawal authorization

I, the undersigned, (if a legal person, herein represented by its duly authorized representative(s)), authorize the Save Your Skin Foundation (SYSF) to deduct the fixed amount I have specified on the accompanying form from the account number on the cheque, on the 15th day of each month.

This constitutes a: personal PAD / business PAD

Waiver:

I hereby waive the written notice confirming changes to this debit.

☐ **I have received a copy of this Agreement and waive all other confirmation before the first payment.**

Change or cancellation:

I shall inform the payee, in a timely manner, of any changes to this Agreement.

I retain the right to revoke my authorization at any time, with a pre-notification of 30 calendar days. To obtain a sample of the cancellation form or for more information on my right to cancel a PAD Agreement, I may contact my financial institution or visit the Canadian Payments Association Web site at www.cdnpay.ca. I agree to release the financial institution of any liability if the revocation is not respected, except in the case of gross negligence on its part.

I agree that the financial institution at which I maintain the account is not required to verify that the payment is debited in accordance with this authorization. I also certify that every person whose signature is required for the operation of the aforementioned account has signed this authorization.

I acknowledge that the delivery of this authorization to the Payee constitutes delivery by me to the aforementioned financial institution.

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PRE-AUTHORIZED DEBIT AGREEMENT

Reimbursement

I have certain rights of recourse is a debit does not comply with the terms of this Agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or that is not compatible with the terms of this PAD Agreement. For more information on my rights of recourse, I may contact my financial institution or visit www.cdnpay.ca.

The financial institution shall reimburse me, on behalf of the organization, for any amounts withdrawn in error, within 90 calendar days of the withdrawal for a **personal** PAD and within 10 business days for a **business** PAD, provided that the reimbursement is claimed for a valid reason.

I understand that a claim to this effect must be made to my financial institution following the procedure it will provide for that purpose.

Finally, I acknowledge that a claim for reimbursement filed after the aforementioned time limits must be settled between me and Payee, without any liability or commitment on the part of my financial institution.

Consent to disclosure of information

I hereby consent to the disclosure of the information contained in by pre-authorized debit enrolment agreement to the financial institution, provided such information is directly related to and required for the smooth application of the rules governing pre-authorized debits.

Signature of account holder(s)

_____ _____

Signature of account holder Date (dd/mm/yy)

_____ _____

Signature of second account holder (if required) Date (dd/mm/yy)

Important: Attach a personal cheque marked "VOID" to avoid errors in transcription.
If you change your account or financial institution, please advise the payee organization.