

Pre-Authorized Debit Agreement (PAD)

IFS Financial Services Inc.
Suite 1, 250 Brownlow Ave
Dartmouth, Nova Scotia B3B 1W9
Phone 800-565-1153
Fax 800-453-5736

IFS Account Information

Account Number _____ (10 digits)

Account Name _____ (Name(s) of all Insured(s))

Bank Account Information

Institution Name _____

Institution Number _____ (3 digits)

Branch Number _____ (5 digits)

Account Number _____

Type of Service (please check one) Personal

Business

I/We _____ authorize IFS Financial Services Inc (IFS)

Print account holder name

to debit my/our bank account for the monthly payment of \$ _____ due IFS on or

Payment Amount

about the _____ th day of each month commencing _____

Day of Month

Due Date of next payment

I/We may revoke my/our authorization at any time, subject to providing notice of 30 days. To obtain a sample cancellation form, or for more information on my/our right to cancel a PAD Agreement, I/we can contact my/our financial institution or visit www.cdnpay.ca

I/We have certain resource rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with the PAD Agreement. To obtain more information on my/our rights, I/we may contact my/our financial institution or visit www.cdnpay.ca

Authorized Signature(s) _____

Signature of Account holder

Date

Please attach a **VOID cheque** so that we may record your correct banking information.