SCHEDULE "A" to POLICY GGS-14

RURAL MUNICIPALITY OF
ST. ANDREWS

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 #

PRE - AUTHORIZED DEBIT FORM FOR TIPPS

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

☐ **CANCELLATION** **Effective Date:** _____

Customer Information:

Name		
Mailing Address		
City	Province	Postal Code
Home Phone	Business Phone	Email

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 day of any month, **in writing**. Such notice shall not have effect on debits made prior to cancellation.

** **NOTE:** 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.

** **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.**

OFFICE DATE STAMP

Customer Name _____

Signature _____

Date _____

BE SURE TO INCLUDE DIGITAL PRINTOUT OF BANK ACCOUNT INFORMATION OR A VOID CHEQUE