

## Pre-Authorized Payment (PAP) Enrollment Form Please return this by Mail to : PO Box 1749, Halifax, NS B3J 3A5 or Fax to: 902-490-4005

For Information Please Contact us at 311, 1-800-835-6428(NS only) or cashmgmt@halifax.ca

PLEASE SELECT ONLY ONE PRE-AUTHORIZED PAYMENT OPTION BELOW. ALSO BE SURE TO ENCLOSE A VOID CHEQUE WHEN **RETURNING THIS FORM TO HRM.** 

Payments for: PROPERTY 1		LOCAL IMPROVEMEN		BENEFITS REPAYMENT Option 2 - Monthly only	Other
Customer Information					
Customer Name:	Email:				
Customer Address:					
HRM Assessment #:			Daytime Pho	ne #:	
Banking Information (MUST ATTACH VOID CHEQUE OR AUTHORIZED BANK INFORMATION)					
Banking Information: Your regular payment will be debited from the account provided on the attached. [MUST ATTACH VOID CHEQUE, OR AUTHORIZED BANKING INFORMATION PROVIDED BY YOUR BANK.] Must be a Canadian recipient holding a bank account in Canadian \$. Banking information must include Bank Name, Branch Number, Institution Number and Account Number.					
Pre-Authorized Payment Options (only select 1 option)					
	int your name		-	unicipality to debit my bank Interim and Final tax bills.	account
OPTION 2 - Mon If you are selecting th I Please print y I would like my pay	e Monthly or Biw /our name	veekly option, please fill *** for the Mont , authorize Ha	thly option, only da	ow and check the appropriat ates of the 1st or the 15th are unicipality to debit my bank Bi-Weekly for the amount of \$	valid ***
Month Recourse Rights					
You (or I/We, depending on the context) have certain recourse rights if any debit does not comply with this agreement. For example, you(I/we) have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAP agreement. To obtain more information on your(my/our) contact your (my/our) financial institution or visit www.cdnpay.ca           Cancellation Terms           This authorization may be cancelled upon notice by me/us to Halifax Regional Municipality as least fifteen(15) business days prior to the next					
scheduled debit.					
Change of Bank Account information or Increasing/Decreasing Payment amount If there is a change in Banking information such as a new account and/or closed account, or you wish to increase or decrease the amount we					
are debiting from your bank account, please provide a written request within fifteen(15) business days prior to the next scheduled debit.					
Returned Debit from the bank (example: Non-Sufficient Funds NSF)					
If your Pre-Authorized Payment is returned by the bank for any reason, two(2) returned debits will result in removal from the Pre- Authorized payment program. I HAVE READ AND AGREE TO THE TERMS & CONDITIONS LISTED ABOVE					
Date	<u></u>	ne(please print)		Signature	

Name(please print)

Signature

In accordance with Section 485 of the Municipal Government Act (MGA), the personal information collected on this form will only be used by HRM staff for purposes relating to the payment of interim and final tax bills. If you have any questions about the collection and use of this information, please contact the Access and Privacy Office at 902-490-4390 or accessandprivacy@halifax.ca