



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 TAXES** **LOCAL IMPROVEMENT CHARGES** **BENEFITS REPAYMENT** **Other**
Option 2 - Monthly only

Customer Information

Customer Name:	Email:
Customer Address:	
HRM Assessment #:	Daytime Phone #:

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)

OPTION 1 - Due Date

I _____, authorize Halifax Regional Municipality to debit my bank account
Please print your name
on the last business day in April and October of each year for the amount of my Interim and Final tax bills.

OPTION 2 - Monthly or Bi-Weekly

If you are selecting the Monthly or Biweekly option, please fill in the details below and check the appropriate box.
*** for the *Monthly* option, you can only select dates between the 1st and the 28th of the month ***

I _____, authorize Halifax Regional Municipality to debit my bank account
Please print your name

Monthly OR **Bi-Weekly**

I would like my payments to start the _____ day of _____ for the amount of \$ _____
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, a fee of \$40.00 will be applied to your account. 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 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

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