MEDICAL PHARMACIES

Medical Pharmacies Group Limited
300 Town Centre Blvd, 4th floor
Markham, ON L3R 5Z6

Pre-Authorized Payment Plan
A convenient way to pay your statement

To enroll in the Pre-Authorized Payment Plan, please fill in the form below and return it by mail or fax it to 1-855-474-7065.

Pre-Authorized Payment Plan Agreement

I/We authorize my/our financial institution to debit my/our bank account on the 25th day following the statement date, or debit my/our credit card, for the full balance owing to Medical Pharmacies Group. This authorization is valid for amounts drawn on the financial institution specified by the voided cheque attached or any other account which I/we may designate in the future in lieu of the account specified here or to the credit card number specified. This authority is to remain in effect until Medical Pharmacies Group has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information or my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca. I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/We have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/We may contact my/our financial institution or visit www.cdnpay.ca.

***PLEASE PRINT**

Type of Service: ☐ Personal ☐ Business

Customer Name: _____

Home Name/Facility: _____ City: _____

Responsible Party Name: _____
(*Name of invoice recipient if different than customer name)*

Address: _____ City: _____

Province: _____ Postal Code: _____ e-mail: _____

Phone Number (Home): _____ Phone Number (Bus.): _____

Please select your payment option (a or b) and provide authorization signature(s)* (c) below:

(a) ☐ ***Automatic Withdrawal from Bank Account*** **(Please enclose a VOID Cheque)†**

Name of Financial Institution: _____

Transit #: _____ Institution #: _____ Account #: _____

(b) ☐ ***Credit Card:*** ☐ Visa ☐ MasterCard ☐ American Express

Name on Card: _____ **Card Verification Code‡:** _____

Credit Card Number: _____ Expiry Date (MM/YYYY): _____

(c) ***Authorized Signature(s)*:*** _____ Date: _____

** For joint accounts where more than one signature is required on cheques, please have ALL account holders sign this form.*

† See back for illustrative example of cheque.

‡ See back for illustrative of example of Card Verification Code.

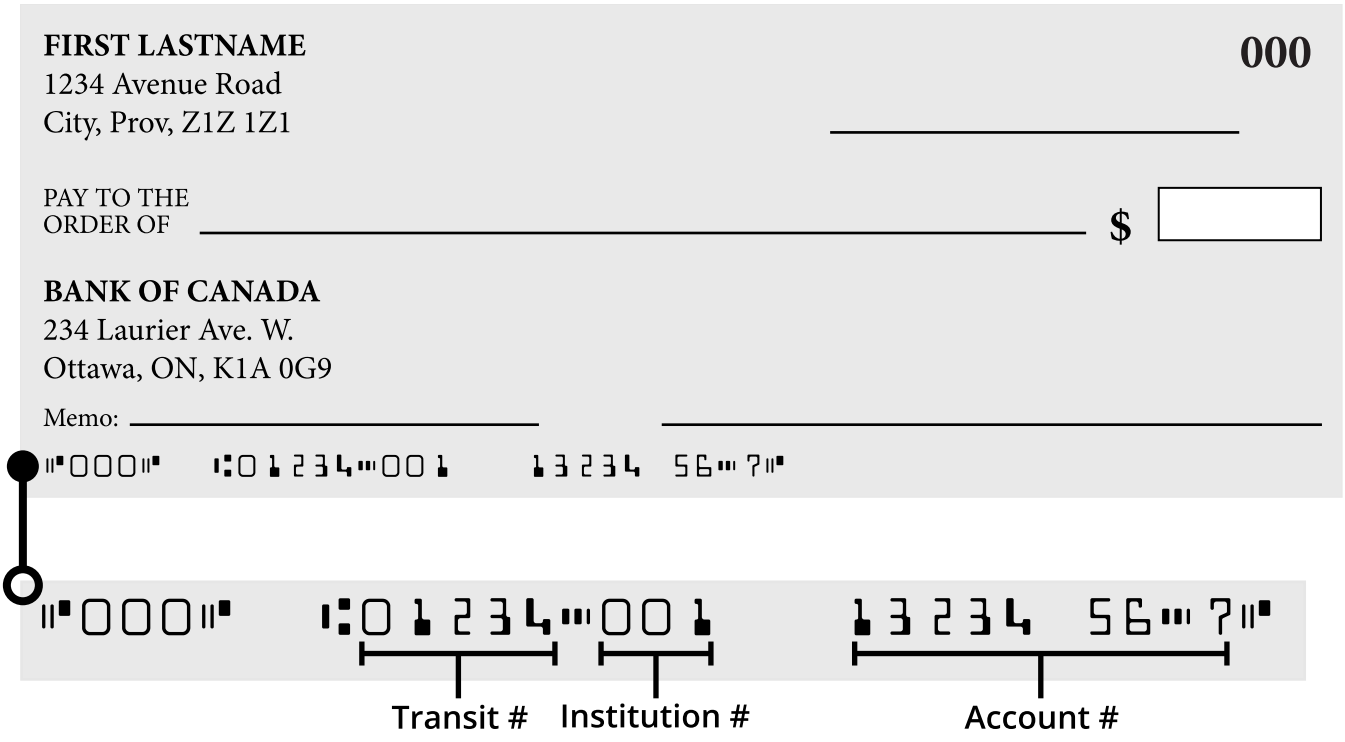
Medical Pharmacies Group Limited
☎ 1-888-841-4049 ✉ billing@medicalpharmacies.com
medicalpharmacies.com

MEDICAL PHARMACIES

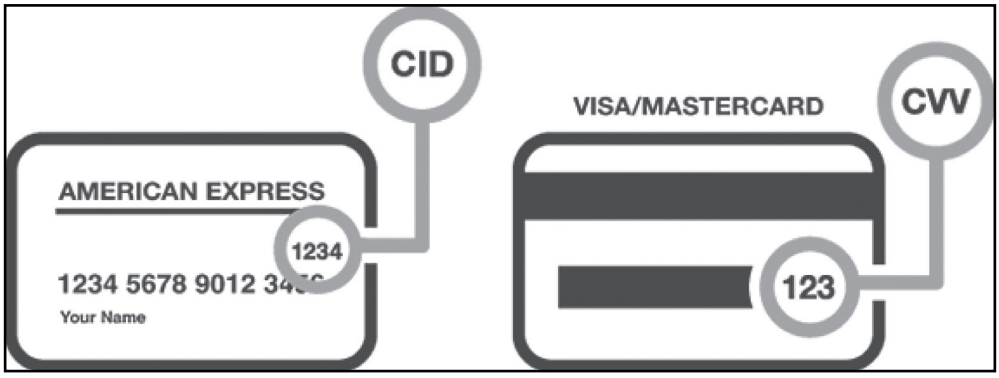
CANADA'S BEST MANAGED COMPANIES Platinum member

Illustrative Examples for finding your Financial Information

†Locating your Bank Account Information:



‡Locating your Card Verification Number:



If you need any further assistance, please do not hesitate to call 1-888-841-4049.