



Please complete the Pre-Authorized Debit (PAD) Plan agreement below.

**IMPORTANT: You must mail in, fax in, or email a scan of a "VOID" Check otherwise your order may get delayed.**

### Customer Information

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
Country

\_\_\_\_\_  
State / Province

\_\_\_\_\_  
Zip/Postal Code

\_\_\_\_\_  
Phone (Home)

\_\_\_\_\_  
Email

### Bank Account Information

\_\_\_\_\_  
Bank Name

\_\_\_\_\_  
Bank Address

\_\_\_\_\_  
Bank Phone Number

\_\_\_\_\_  
Name on the Account

Business

Personal

ABA Routing Number | | | | | | | | | |

Account Number | | | | | | | | | | | | | | | |

Checking

Saving

### Pre-Authorized Details

I / We authorize FederalDrugs and the financial institution designated to begin deductions as per my / our instructions for regular one-time payments from time-to-time for payment of all charges arising under my/ our FederalDrugs account. My / Our Pre-Authorized Payment debit will be processed with a 24 hour period for the amount that will be confirmed.

The Canadian Payment Standards require a 15 day notification period before first scheduled debit. I / We agree to shorten the notice period of the first scheduled PAD to 3 days.

The Canadian Payment Standards require a 10 day notification period before debiting an account . I / We agree to shorten the notice period of the PAD amount to 24 hours.

In the instance a verbal pre-notification is provided a post-confirmation will follow. I / We agree to verbal pre-notification of PAP deductions as an accepted form notification.

This authority is to remain in effect until FederalDrugs has received written notification from me / us of its change or termination. This notification must be received at the address listed below at least ten (10) business days before the next debit is scheduled.

I/ We may obtain a sample cancellation form, or more information on my / our right to cancel a PAD agreement at my / our financial institution or by visiting [www.cdnipay.ca](http://www.cdnipay.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 Reimbursement Claim, or for more information on my/ our recourse rights, I/We may contact my/our financial institution or visit [www.cdnipay.ca](http://www.cdnipay.ca)

\_\_\_\_\_  
Signature of **Account Holder**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Of **Joint Account Holder** (if applicable):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

**Federal Drugs**  
2 Toronto St. Suite 462 Toronto, ON,  
Canada M5C 2B5

Phone(toll free) : 1-877-333-5544  
Fax(toll free): 1-877-333-4404  
Email: [info@federaldrugs.com](mailto:info@federaldrugs.com)