Cells for Life Cord Blood Institute Inc.

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

I/we authorize Cells for Life Cord Blood Institute Inc., and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin deductions as per my/our instructions for monthly and/or annual regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my Cells for Life account(s).

You the Payor authorize Cells for Life to debit the bank account identified below for:

Initial Payment:

☐ **For payment of your processing & storage fees in FULL;** payments in the amount of $_____ will be debited to my/our specified account on the **1st Friday following the invoice due date**.

☐ **For payment of your processing and storage fees in 3 monthly installments;** Regular monthly payments in the amount of $_____ will be debited to my/our specified account on the **1st Friday following the invoice due date**.

☐ **For payment of your processing and storage fees in 12 monthly installments;** Regular monthly payments in the amount of $_____ will be debited to my/our specified account on the **1st Friday following the invoice due date**.

Annual Storage:

☐ **For payment of your Annual Storage fee(s);** Regular annual payments for the full amount of $_____services delivered will be debited to my/our specified account on the **1st Friday following the invoice due date.**

Cells for Life will obtain my/our authorization for any other one-time or sporadic debits.

This authority is to remain in effect until Cells for Life Cord Blood Institute Inc. 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 on 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

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PLEASE PRINT & RETURN BEFORE CORD BLOOD COLLECTION

Cells for Life Registration Number:_____

Name(s):_____

Address:_____ Type of Service: Personal _____ Business _____

City/Town:_____ Province:_____ Postal Code:_____

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

Name(s) on the Account (if different than above):_____

Financial Institution (FI):_____

FI Account Number:_____ FI Transit Number: _____ - _____

(Branch -5 digits; FI – 3 digits)

FI Address:_____

City/Town:_____ Province: _____ Postal Code:_____

Authorized Signature(s):_____ _____

Date:_____

Cells for Life Cord Blood Institute Inc.
Attention: Accounts Receivable Department
402-379 Church Street
Markham, Ontario L6B 0T1
Tel: 905-201-3393 E-mail: accounts@cellsforlife.com Fax: 905-472-2185