



Pre-Authorized Payment (PAP) Enrollment

Please return this by Mail to: PO Box 1749, Halifax, NS B3J 3A5

By Email to: cashmgmt@halifax.ca

For More 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:

For PROPERTY TAXES Only:

New Agreement

Change to Existing Agreement

PLEASE ENSURE TO ENCLOSE A VOID CHEQUE WHEN RETURNING THIS FORM TO THE MUNICIPALITY

Customer Information	
Customer Name:	Email:
Customer Address:	
Account #:	Daytime Phone #
Payments for (select one):	<input type="checkbox"/> Personal Use <input type="checkbox"/> Business Use
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 domiciled bank account in Canadian funds. Banking information must include Bank Name, Branch Number, Institution Number, Account Number and Account Holder Name.	
Change of Account Information: If there is a change in banking information such as a new account and/or closed account, please provide a New Pre-Authorized Payment (PAP) Enrollment Form at least fifteen (15) business days prior to the next scheduled debit.	
Pre-Authorized Payment Options (only select 1 option)	
<input type="checkbox"/> OPTION 1 – Due Date	
I _____, authorize Halifax Regional Municipality to debit my bank account on the last business day of _____, <small>Please print your name</small> April and October of each year for the amount of my interim and final tax bills.	
<input type="checkbox"/> OPTION 2 – Monthly or Bi-Weekly	
Please Indicate: <input type="checkbox"/> FIXED AMOUNT <input type="checkbox"/> VARIABLE AMOUNT (Based on bi-annual auto-calculation)	
I _____, authorize the Halifax Regional Municipality to debit my bank account <small>Please print your name</small> <input type="checkbox"/> Monthly* or <input type="checkbox"/> Bi-Weekly	
I would like my payments to start the _____ day of _____ for the amount of \$ _____.	
Should you wish to increase or decrease the amount we are debiting from your bank account, please reach out to the contact information above at least fifteen (15) business days prior to the next scheduled debit.	
*For the monthly option, you can only select dates between the 1st and the 28th of the month.	
Recourse Rights	
You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.payments.ca .	
Cancellation Terms	
This authorization may be cancelled upon notice by you to Halifax Regional Municipality at least fifteen (15) business days prior to the next scheduled debit. For additional information on your right to cancel a PAD Agreement, please contact your financial institution or visit www.payments.ca .	
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 may be applied to your account. Two (2) returned debits may 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
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In accordance with Section 485 of the Municipal Government Act (MGA), the personal information collected on this form will only be used by municipal 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 902-943-2148 or privacy@halifax.ca