Ontario Health Coalition
Monthly Giving Plan & Regular Membership

Municipality or Organization: _____

Contact Name: _____

Mailing Address: _____

City/Town:_____ Postal Code: _____

Phone: (H) _____ (W) _____

Phone: (C) _____ Email:_____

□ I am a new member (please check if applicable)

□ I am renewing my membership (please check if applicable)

Your Support Leads to Success

Your support is what enables the Ontario Health Coalition to do all that we do to protect and improve health care under the principles of the Canada Health Act in Ontario's communities. Some of our collective successes:

- Our deep community organizing has led to a significant majority of Ontarians opposing health privatization
- We've moved all opposition parties to oppose health privatization
- We won improved funding and care standards in long-term care homes

We hate to have to ask, but please be assured, your memberships, donations, and participation in our garlic fundraiser and other initiatives make all the difference. Thank you so much!

PLEASE JOIN OUR MONTHLY GIVING

Under this plan, a set amount will be withdrawn directly from your account each month as a personal donation to the Ontario Health Coalition.

YES! I will give per month a fixed amount monthly:
(circle one) $5 $10 $20 other_____

Every 1st or 15th of the month (circle one).
Starting date: _____, 2024

Please attach a blank voided cheque.
If only 1 signature is required for the account, then only 1 Payor need sign. If 2 or more signatures are required, then both or all Payors must sign.

I/We authorize the Ontario Health Coalition to debit my account with the financial institution noted on my cheque for the amount and frequency described above until written notice to the contrary is given.

Payor signature(s):

_____

Date:

_____

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with the PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca

This Authorization may be cancelled at any time upon notice being provided by me either in writing or orally, with proper authorization to verify my identity within 10 days before the next PAD is to be issued. I acknowledge that I can obtain a sample cancellation form or further information on my right to cancel this Agreement from the Ontario Health Coalition or by visiting www.cdnpay.ca

CAN'T GIVE MONTHLY?
ANNUAL MEMBERSHIP FEES 2024

Individual members: $20

Organizations:
Under 100 members: $25

Over 100 members, membership rates set at $0.20 per member, e.g:

500 members = $100
1,000 members = $200
5,000 members = $1,000
10,000 members = $2,000 etc.

Municipalities:
Population under 49,999: $100
Population 50,000-99,999: $200
Population over 100,000: $300

Your membership fee rate enclosed is $_____

Additional donation (circle one):

$20 $50 $100 $200 $500 $1000

Is this a membership renewal? (check one)

□ **Yes** □ **No** □ **Not Sure**

Please fill out this form and send it to us at:

Ontario Health Coalition
15 Gervais Drive, Suite 201
Toronto, Ontario M3C 1Y8

Phone: 416-441-2502
E-mail: info@ontariohc.ca

Check us out online at: www.ontariohealthcoalition.ca