

Ontario Health Coalition

Medicare Supporters Monthly Giving Plan and Regular Membership form

Organization (if applicable) _____

Contact Name: _____

Mailing Address: _____

City/Town: _____ Postal Code: _____

Phone: (H) _____ (W) _____

Fax: _____ E-mail: _____

PLEASE JOIN OUR MONTHLY GIVING PLAN!!

Under this plan, a set amount will be withdrawn directly from your account each month.

YES! I will give per month:

(circle one) \$5 \$10 \$20 other _____

Every 1st or 15th of the month (circle one)

Starting date: _____, 2009

Please attach a blank voided cheque.

I/We the undersigned authorize the Ontario Health Coalition to debit my/our account at the Financial Institution indicated, under the terms and conditions agreed to by me/us with the Ontario Health Coalition until such time as written notice to the contrary be given by me/us to the Ontario Health Coalition. (The Ontario Health Coalition will notify you in writing of any change in the above noted amount, date or frequency at least 10 calendar days before the pre-authorized debit is due.) I/We have read and understood the terms and conditions below and hereby accept them as a condition of my/our participation in the Ontario Health Coalition's Medicare Supporters Monthly Giving Plan.

Signature of Account Holder

Date

(joint signature ONLY if required) _____
Signature of Account Holder

Date

CAN'T GIVE MONTHLY? ANNUAL MEMBERSHIP FEES 2009

Individual members: \$10

Organizations:

Under 100 members \$25

Over 100 members, membership rates set at \$0.10 per member, for eg.

500 members = \$50

1,000 members = \$100

5,000 members = \$500

10,000 members = \$1,000 etc.

Your membership fee rate enclosed is \$ _____

Additional donation (circle one):

\$20

\$50

\$100

\$200

\$500

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

Ontario Health Coalition 15 Gervais Drive, Suite 305, Toronto, Ontario M3C 1Y8

Phone: 416-441-2502 Fax: 416-441-4073 Email: ohc@sympatico.ca

Check us out online at: www.ontariohealthcoalition.ca