



CANCEL DEBIT CARD

Date _____

Credit Union
Account # _____

Cardholder
Name _____

Phone # _____

Debit Card # 5146-17 - - - - -

**I request that ProMedica Federal
Credit Union cancel my Debit Card.
I am responsible for any transaction
that may post after I cancel my card.***

Reason for Closing _____

**Date Of Card
Cancellation** _____ / _____ / _____

**Member
Signature** _____ **Date** _____

OFFICE USE



Received By _____ **Date** _____

* It takes at least 24 hours to update transactions on member accounts. Transactions over a weekend will not post until Monday after midnight. Please take this into consideration when canceling your card.