VISA® BALANCE TRANSFER AUTHORIZATION FORM

Member Name: _________________________________ Member Number: ____________________________

Daytime Phone #: ________________________________

PFCU Visa account #: _______-_______-_______-_______

CARDS TO BE TRANSFERRED:

Issuing Institution:	Account Number:
Payment Address:	Amount to Pay:
Issuing Institution:	Account Number:
Payment Address:	Amount to Pay:
Issuing Institution:	Account Number:
Payment Address:	Amount to Pay:

TRANSFER AGREEMENT

By signing below, I authorize you to bill my ProMedica Federal Credit Union (PFCU) Visa® account in the full or partial amount(s) for the Amount To Pay indicated above. I understand that, although most balance transfers will be made sooner, transfers can take up to 4 weeks. Accordingly, I will continue to make all required payments until I confirm that the balance transfer has been made. PFCU is not responsible for charges I may incur on my other account as a result of a balance transfer request. My accounts at PFCU must be in good standing at the time the balance transfer offer is processed. See Cardholder Agreement Credit Card Agreement and Truth-In-Lending Disclosure for additional information. I understand that you will advise me if you are unable to process my payment request for any reason. Balance transfers are not valid for payment of PFCU loans or PFCU Visa® card balances.

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Cardholder Signature Date

Please complete the form, print it, sign it and fax it to: 419.471.1837