VISA Balance Transfer Request Form

YES, PLEASE TRANSFER MY OUTSTANDING CREDIT CARD BALANCES LISTED BELOW SO I CAN BEGIN SAVING MONEY: *My Member Number is:* _____

Name of Creditor: _____

Street or PO Box: _____

City, State, Zip: _____

Account Number: _____

Payoff Balance: _____

Name of Creditor: _____

Street or PO Box: _____

City, State, Zip: _____

Account Number: _____

Payoff Balance: _____

Name of Creditor: _____

Street or PO Box: _____

City, State, Zip: _____

Account Number: _____

Payoff Balance: _____

By signing this agreement, I/We agree to be-governed by the terms and conditions of the Visa account as described in the disclosure statement and notice of billing rights that are mailed to me from Visa. The statement here in is made for the purpose of obtaining credit and is true, accurate, and complete to the best of my/our knowledge and belief. I/We understand Ohio HealthCare FCU will retain this application whether or not it is approved. The Ohio HealthCare FCU is authorized to check my credit and employment history and to address questions about my credit experience. Ohio HealthCare FCU is authorized to pay off the credit cards listed and to transfer the balance to my Ohio HealthCare FCU Visa card. I/We understand the transfers are treated as cash advances and that finance charges will be applied from the day the balance is transferred to my card.

Applicant's Signature	Print Name	Date
Co-Applicant's Signature	Print Name	Date

For Office Use Only:	
Staff Initials: _____ Date: _____	☐ Check to Member ☐ Check to Card Companies ☐ Check Stubs

Ohio HealthCare FEDERAL CREDIT UNION
You care for others, we care for you.

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