

VISA Balance Transfer Request Form

YES, PLEASE TRANSFER MY OUTSTANDING CREDIT CARD BALANCES LISTED BELOW SO I CAN BEGIN SAVING MONEY:

Name of Creditor: _____
Street or PO Box: _____
City, State, Zip: _____
Account Number: _____
Payoff Balance: _____

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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 herein 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 payoff 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:			
Cks to Mbr :	To Card Companies:	Staff Initial:	Ck Stubs: