Credit Card Balance Transfer Application

Member Number

Member Name

Social Security Number xxx xx

Email address

Creditor to be paid:

Name of Creditor

Account Number

Mailing Address

City, State, Zip

Balance Transfer Amount $

*There is no cash advance fee for a balance transfer. Interest will begin to accrue at the transfer date. Balance transfers may not exceed available credit limit.

I authorize My Healthcare Federal Credit Union to process the requested amount to My Healthcare Federal Credit Union's credit card account. Please allow 5-10 business days for payment to be received by Creditor. Charges which are incurred, pending, or outstanding on your account with the Creditor above may result in this advance failing to pay in full the balance due. It is your responsibility as the account holder to pay any charges incurred on the account with the Creditor above beyond the balance transfer amount. Should the account need to be closed, this is the account holder's responsibility.

Signature: _____ **Date:** _____

This form must be faxed or mailed to us with your signature.

Fax: (352) 333-4805

Mailing Address: My Healthcare Federal Credit Union
4720 NW 39th Avenue
Gainesville, FL 32606

Update: Feb 2018