

Your financial health. Our mission.

Received by _____

DATE: ____ / ____ / ____ CU ACCT _____

CARDHOLDER NAME: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME# _____ WORK/CELL# _____

OCCUPATION: _____ MOTHERS MAIDEN NAME: _____

DEBIT CARD# 5146-17 ____ - ____ - ____ REPLACE: Y N SAME# Y N

ATM CARD# 5845-97 ____ - ____ - ____ REPLACE: Y N SAME# Y N

CARD BEING REPLACED DUE TO:

- DAMAGED CARD
- MAG STRIP DAMAGED
- LOST/STOLEN
- NEVER RECEIVED IN MAIL
- NAME CHANGE
- COMPROMISED

****CHARGE FEE TO: CHECKING SAVINGS NO CHARGE

***FEE DEPENDS ON NUMBER OF PREVIOUS REPLACEMENT CARDS
1ST REPLACEMENT CARD \$5; 2ND REPLACEMENT CARD \$10; 3 OR MORE REPLACEMENT CARDS \$20 EACH TIME

MEMBER SIGNATURE _____ DATE _____
SIGNATURE REQUIRED FOR NEW CARD

REQUEST FOR PIN CHANGE

I REQUEST A PIN CHANGE. I WOULD LIKE MY PIN # TO BE _____. (4 DIGITS)

MEMBERS SIGNATURE _____ DATE _____

REQUEST TO CANCEL DEBIT CARD

I REQUEST THAT PROMEDICA FEDERAL CREDIT UNION CANCEL MY DEBIT CARD. I AM RESPONSIBLE FOR ANY TRANSACTIONS THAT MAY POST AFTER I CANCEL MY CARD.

REASON FOR CLOSING _____

MEMBERS SIGNATURE _____ DATE _____

OFFICE USE ONLY

NEW DEBIT CARD NUMBER _____

MAINTENANCE/NEW CARD ORDERED BY _____ DATE _____