



HEALTH SAVINGS ACCOUNT DEBIT CARD APPLICATION

WESTconsin Credit Union Member # _____

Checking Account Suffix #81

PRIMARY CARDHOLDER INFORMATION

Name _____
First Last

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____

PLEASE LEAVE THIS AREA BLANK

Date Entered ____/____/____ by _____ Debit Card Number _____

POA CARDHOLDER INFORMATION

Name _____
First Last

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____

PLEASE LEAVE THIS AREA BLANK

Date Entered ____/____/____ by _____ Debit Card Number _____

The undersigned give(s) the information in this application for the purpose of obtaining a Health Savings Account Debit Card from WESTconsin Credit Union. I/We certify that the information is true and complete and authorize WESTconsin Credit Union to investigate my/our financial responsibility through any reasonable means. I/We have received and will comply with WESTconsin Credit Union's MEMBERSHIP AND ACCOUNT AGREEMENT, ELECTRONIC FUND TRANSFERS AGREEMENT AND DISCLOSURE and SERVICE CHARGES AND FEES brochure. I/We understand that if I/We receive a debit card and have overdrafts in a period of time, WESTconsin Credit Union may close my/our account. In addition, I/We understand and agree that each person who holds a card to access this account and any persons to whom the card is given may access my/our account with it.

Date _____

SIGNATURE OF PRIMARY CARDHOLDER

Date _____

SIGNATURE OF POA CARDHOLDER *(when applicable)*

PLEASE DROP THE COMPLETED APPLICATION OFF AT YOUR LOCAL OFFICE OR MAIL TO:

WESTconsin Credit Union
Attn: Electronic Services Dept.
PO Box 160
Menomonie, Wisconsin 54751