WESTconsin CREDIT UNION®

HEALTH SAVINGS ACCOUNT DEBIT CARD

APPLICATION

*WEST*consin Credit Union Member # ______________________ Checking Account ID ☐☐☐☐

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 *WEST*consin Credit Union. I/We certify that the information is true and complete and authorize *WEST*consin Credit Union to investigate my/our financial responsibility through any reasonable means. I/We have received and will comply with *WEST*consin 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, *WEST*consin 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:

*WEST*consin Credit Union
Attn: Electronic Services Dept.
PO Box 160
Menomonie, Wisconsin 54751

CLEAR FORM PRINT