WESTconsin® CREDIT UNION
We belong to you.™

Health Savings Account Debit Card APPLICATION

*WEST*consin Credit Union Account # _____ 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 549683000 _____

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 549683000 _____

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_____ _____ Date_____

SIGNATURE OF PRIMARY CARDHOLDER **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

Federally insured by NCUA