

OVERDRAFT COVERAGE APPLICATION

APPLICANT'S NAME (PRIMARY MEMBER)

ADDRESS

CITY

STATE

ZIP

TELEPHONE NUMBER

CO-APPLICANT OR JOINT OWNER

CHECKING ACCOUNT NUMBER(S)

CREDIT UNION USE ONLY: Employee

Branch #

SELECT ONE: ADD REMOVE OVERDRAFT COVERAGE FROM SAVINGS

SAVINGS ACCOUNT NUMBER _____

ADD REMOVE OVERDRAFT COVERAGE FROM VISA®

VISA® CREDIT CARD NUMBER _____

Apply now and begin enjoying the peace of mind that Overdraft Coverage provides!

I/We apply for Overdraft Coverage. I/We agree this application shall remain the property of the Credit Union whether overdraft coverage is granted or denied. I/We have read the terms, fees, and conditions as stated in this application and agree to same. I/We understand that if we select Savings Overdraft Coverage and there are nonsufficient funds in my/our savings' accounts, the Credit Union will be under no obligation to provide this service. I/We understand that I can elect to have the **Overdraft Coverage from my savings OR VISA® credit card**. For Overdraft Coverage from my/our Savings, I/we understand there is a limit of 6 automatic, pre-authorized, or third-party transfers from my/our savings account per month. I/We understand there is a fee for Savings Overdraft Coverage.

SIGNATURE (PRIMARY MEMBER)

DATE

CO-APPLICANT'S OR JOINT OWNER'S SIGNATURE

DATE