

Credit Card Balance Transfer Application

Use this form to transfer balances from other credit unions and loans to your My Healthcare Federal Credit Union credit card. There is no cash advance fee to transfer. Interest will begin to accrue at the transfer date.

Member Number

First Name

Last Name

Social Security Number

Date of Birth

Your email address

My Healthcare Federal Credit Union Visa Number

Information on Institution to be paid:

Account number of credit card/loan to be paid

Name of Institution

Address

City, State, Zip

Pay off balance amount

Pay-off balance must not exceed current credit limit.

I authorize My Healthcare Federal Credit Union to transfer my existing account balance to My Healthcare Federal Credit Union credit card account. Please allow 5-10 business days for payment. There may be outstanding charges on your account and this advance may not pay off the total balance due. It is your responsibility to close out your credit card or loan at the above named institution if you wish to do so. (This will help you avoid any annual fee that is assessed to your account.)

Signature: _____

Date: _____

This form must be faxed or mailed to us with your signature.

Fax: (352) 333-4805

Mailing Address: My Healthcare Federal Credit Union
4720 NW 39th Avenue
Gainesville, FL 32606