CREDIT CARD BALANCE TRANSFER

Member Name: _____

Address: _____

City, State, Zip: _____

CRCFCU Member Account #: _____

CRCFCU MasterCard #: _____

Financial Institution or Card Issuer:	
Account Number:	Pay This Amount: $
Payment Street Address (include P.O. Box, etc.)	
City, State, Zip	

Financial Institution or Card Issuer:	
Account Number:	Pay This Amount: $
Payment Street Address (include P.O. Box, etc.)	
City, State, Zip	

Financial Institution or Card Issuer:	
Account Number:	Pay This Amount: $
Payment Street Address (include P.O. Box, etc.)	
City, State, Zip	

By signing below, I authorize you to bill my approved CrossRoads Community FCU Master Credit Card for the amounts listed above. I understand that you will advise me if you were unable to process my request for any reason.
I understand that CrossRoads Community FCU will not be responsible for any balances exceeding my request or additional finance chages billed to me for the account(s) listed above.

Signature: _____ Date: _____

For internal Use Only Date: _____ Processed By: _____ Total Balance Transfer: $_____