

Transfer of Balance Authorization

Type of card

Account Number

Balance

Mailing Address

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I authorize Health Care Family Credit Union to transfer the account balances listed above to my HCFCU Credit Card.

Print Name

Signature of Cardholder

Date