

Make Your Life A Little Easier!

Apply today for your
HCFCU Credit Card.



Health Care Family
Credit Union

2114 S. Big Bend Blvd.

Richmond Heights, MO 63117

(314) 645-5851

1-866-HCFCU4U

Fax: (314) 645-1548

4599 Executive Centre Pkwy.

St. Peters, MO 63376

www.hcfcu4u.org

E-mail: talktous@hcfcu4u.org



Credit Card Services



*Credit Cards
That Cost You Less!*

When it comes to purchasing power, you won't find a better value than an HCFCU Credit Card. Our cards feature:

- **Low, Fixed Rates**
- No Annual Fee
- 25-Day Grace Period On Purchases
- Worldwide Acceptance
- Online Security Features

Choose from three terrific options:

Visa® Platinum

- 8.9% APR*
- No Annual Fee

Visa® Gold

- 10.9% APR*
- No Annual Fee

MasterCard® Classic

- As low as 12.9% APR*
- No Annual Fee

Plus, a Share-Secured MasterCard is also available.
We have the perfect credit card no matter what your needs!

*APR = Annual Percentage Rate. Card and rate will be based on credit history. See credit union for complete details.

Credit Card Disclosure Table			
Credit Card	Visa Platinum	Visa Gold	MasterCard Classic
Annual Percentage Rate for Purchases, Cash Advances or Balance Transfers	8.9% Rate for cash advance is 8.9% APR from date of advance	10.9% Rate for cash advance is 10.9% APR from date of advance	12.9% – 16.9% Rate for cash advance is the approved rate from date of advance
Grace Period for Repayment of Balances for Purchases	You have 25 days to repay your balance before a finance charge on purchases will be imposed.		
Method of Computing Balance for Purchases	Average Daily Balance (including new purchases)		
Annual Fees	NONE		
Minimum Finance Charge	NONE		
Transaction Fee for Purchases or Cash Advances	NONE		
Additional Features	Cash Advances & Convenience Checks, Worldwide Acceptance, Worldwide Visa ATM network access available with PIN, and ScoreCard Reward Points earned on each eligible purchase.		
Transaction Fee for Paying Late	You agree to pay a late charge for each payment in default for a period of 15 days or more to be applied once to each periodic payment however long it remains in default. If the Minimum Periodic Payment is more than \$25, the charge will be equal to 5% of the Minimum Periodic Payment or \$25, whichever is less, but in no event less than \$10. If the Minimum Periodic Payment is \$25 or less, you agree to pay a late charge of \$5.		
The information about the costs of the cards described is accurate as of 12/10/10. The information may have changed after that date. To find out what may have changed, write to the credit union at the address shown on the back of this brochure.			



DEC10-986TAG



Health Care Family Credit Union

HCFCU Account No. _____

- Individual Account
- Joint Account

If this is an application for joint credit with another person, complete information for both applicants.

CREDIT CARD APPLICATION



This application must be accompanied by verification of income (e.g., recent check stub showing year-to-date income) for each applicant. For some types of income, we may require a copy of W-2s or tax returns.

- Visa Platinum—8.9% fixed APR* & no annual fee
- Visa Gold—10.9% APR* & no annual fee
- MasterCard Classic—as low as 12.9% APR* & no annual fee

I understand that if I do not qualify for the option marked, I will automatically be considered for the other cards offered. Additional information may be required.

*APR = Annual Percentage Rate. Card and rate will be based on credit history. See credit union for complete details.

By signing this form, all applicants named below signify that they intend to apply for joint credit.

Applicant Signature

Co-Applicant Signature

Credit Limit Requested: _____

APPLICANT (LAST/FIRST/MIDDLE)		CO-APPLICANT (LAST/FIRST/MIDDLE)	
ADDRESS	HOW LONG	ADDRESS	HOW LONG
CITY/STATE/ZIP	HOME PHONE	CITY/STATE/ZIP	HOME PHONE
<input type="checkbox"/> OWN <input type="checkbox"/> RENT <input type="checkbox"/> PARENTS	#DEPENDENTS	<input type="checkbox"/> OWN <input type="checkbox"/> RENT <input type="checkbox"/> PARENTS	#DEPENDENTS
SOCIAL SECURITY NO.	BIRTH DATE	SOCIAL SECURITY NO.	BIRTH DATE
EMPLOYER	DATE EMPLOYED	EMPLOYER	DATE EMPLOYED
WORK ADDRESS	WORK PHONE	WORK ADDRESS	WORK PHONE
POSITION	GROSS MO. SALARY	POSITION	GROSS MO. SALARY
OTHER INCOME (Source/Amount/Frequency)		OTHER INCOME (Source/Amount/Frequency)	
MOTHER'S MAIDEN NAME		MOTHER'S MAIDEN NAME	
RELATIVE not living at same address: (Include name/address/phone)		RELATIVE not living at same address: (Include name/address/phone)	
PREVIOUS EMPLOYER		PREVIOUS EMPLOYER	
PREVIOUS POSITION	HOW LONG	PREVIOUS POSITION	HOW LONG

OUTSTANDING DEBTS (Include charge accounts, installment contracts, credit cards, rent, mortgages, etc. If there are additional debts, list on separate sheet.)		APPROXIMATE MARKET VALUE	INTEREST RATE	BALANCE DUE	MONTHLY PAYMENT
MORTGAGE OR RENT WITH				\$	\$
AUTO LOAN FINANCED BY		ACCOUNT NO.		\$	\$
DEBT (NAME AND ADDRESS)	X			\$	\$
DEBT	X			\$	\$
DEBT	X			\$	\$
DEBT	X			\$	\$
OTHER	X			\$	\$
OTHER	X			\$	\$
PRESENT VISA CARD WITH:	X			\$	\$
PRESENT MASTERCARD WITH:	X			\$	\$

Are you a co-maker, endorser or guarantor on any loan or contract? YES NO To whom?

Other Obligations (Include alimony, child support, separate maintenance, etc. Attach a separate sheet if necessary)

If you are applying for joint credit or if you live in a community property state (AZ, CA, ID, LA, NM, TX, WA, WI, Puerto Rico), complete the following.

Married Separated Unmarried (Includes Single, Divorced, Widowed)

You warrant the truth of the information above and you realize that it will be relied upon by us in deciding whether or not to grant the credit applied for. You hereby authorize us, our employees and agents to investigate and verify any information provided to us by you. You agree and understand that if approved, you are contractually liable according to the applicable terms of the Credit Card Agreement. You will receive a copy of that Agreement no later than the time of your first credit advance and you promise to pay all amounts charged to your Account according to its terms. If this is a joint application, you agree that such liability is joint and several. If you are issued a MasterCard or Visa credit card, you grant and consent to a lien on your shares or other deposits with us (except for IRA or Keogh accounts) and any dividends/interest due or to become due to you from us to the extent you owe on any unpaid Account balance. (initial). You further agree not to use your card for illegal transactions including, but not limited to, advances made for the purpose of gambling and/or wagering where such practices are in violation of applicable State and/or Federal law. By signing below each of the following applicants signify they applied for joint credit.

APPLICANT'S SIGNATURE	CO-APPLICANT'S SIGNATURE
X _____ Date _____	X _____ Date _____

CREDIT LIFE AND DISABILITY INSURANCE: "You" or "Your" means the member and the joint insured, if applicable; "Us" means the Credit Union. Credit insurance is voluntary and not required in order to obtain this loan. You may select any insurer of your choice. You can get this insurance only if you check the "yes" box below and sign your name and write in the date. The rate you are charged for this insurance is subject to change. You will receive written notice before any increase goes into affect. You have the right to stop this insurance by notifying us in writing. Your signature below means you agree that: 1) If you select insurance, you authorize us to add the charges for insurance to you loan each month. 2) You are eligible for disability insurance only if you are working for wages or profit for 25 hours a week or more on the date of any advance. If you are not, that particular advance will not be insured until when you reach that age. 4) You agree to pay the charge show.

Cost/Disclosure: Credit Life rate per \$100 of the Monthly Loan Balance is \$.08 for Single Coverage or \$.124 for Joint Coverage. Credit Disability rate per \$100 of the Monthly Loan Balance is \$.278 for Single Coverage or \$.501 for Joint Coverage.

Single Credit Disability Single Credit Life Member Signature _____ Date of Birth _____ Date _____

Joint Credit Disability Joint Credit Life Joint Member Signature _____ Date of Birth _____ Date _____

TRANSFER OF BALANCE REQUEST: I wish to transfer my present balance on the account(s) marked with a circled "X" above or listed below.

MasterCard Account No. _____ Visa Account No. _____ Account No. _____

Signature _____	HCFCU USE ONLY Loan Officer Signature	Date _____	<input type="checkbox"/> Denied
	Attach the payment coupon from your most recent statement.	Limit \$ _____	<input type="checkbox"/> Approved
		Counter _____	<input type="checkbox"/> Counter