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9.9% for Life Balance Transfer Form

Complete the following and return to any credit union location.

Member Name: _____

HAFCU Account Number: _____

Phone Number: _____

I hereby authorize Health Advantage FCU to complete a CASH ADVANCE charged to my Health Advantage Credit Union credit card, up to my available limit, at **9.9%APR** for the LIFE of the Balance* for the following credit cards. I understand the funds will be deposited to my Health Advantage checking account to pay the following merchants:

1) Credit Card Name/Issuer: _____
   Credit Card Account Number: _____
   Transfer Amount: _____

2) Credit Card Name/Issuer: _____
   Credit Card Account Number: _____
   Transfer Amount: _____

3) Credit Card Name/Issuer: _____
   Credit Card Account Number: _____
   Transfer Amount: _____

4) Credit Card Name/Issuer: _____
   Credit Card Account Number: _____
   Transfer Amount: _____

I understand that Health Advantage Credit Union is not responsible for my payment being late or lost in the mail to the above companies. I also understand that there may be outstanding charges on my account and this advance may not pay off the total balance due. I understand that it is my responsibility to close out my charge account at the above named institution to avoid any annual fees that may be assessed to my account.

***9.9%APR is valid until the entire balance is paid in full and only applies for balances transferred from another financial institution. If you are 60 days delinquent and receiving a promotional balance transfer rate, this rate may automatically revert to the originally disclosed balance transfer rate. APR for purchases will remain at the originally disclosed rate.**

_____ _____

Primary Cardholder Signature Date

For Office Use Only

Deposit Account: _____ Referral Teller: _____ Date: _____

Health Advantage Credit Union
989-791-7070 • www.healthadvantagecu.com