



Automatic VISA Payment Request Form

Member: _____

Visa Account #: _____

I authorize Finger Lakes Health Care FCU to debit the account listed below and apply it to my Visa. I can choose to have a specified amount paid each month, the minimum payment that is due each month, or the entire outstanding balance.

_____ Pay \$ _____ on the _____ day of each month

_____ Pay the minimum amount that is due each month on the date that it is due

_____ Pay the entire outstanding balance on the date that it is due.

Account #: 11280000 _____

Account Type: Checking Savings (circle one)

I further understand that if the amount indicated above is not available in the account listed above on the agreed date, I may be subject to fees from the credit union; ie. NSF, return fees, late payment, etc.

In order to revoke this authorization, the credit union must receive a written statement indicating that you would like this automatic transfer stopped. It must be received at least 10 (ten) days prior to the agreed date.

Member's Authorization

Date

For Credit Union Use Only:
Accepted by: _____
Date: _____