AdventHealth Credit Union

REQUEST TO RAISE DEBIT CARD LIMIT

VISA Debit Card #: _____ Name: _____ Account: _____

☐ **One Time Temporary Limit Increase**	☐ **Permanent Limit Increase*** *Account balance must be positive for the last 12 months.*

☐ Increase Point of Sale debit card limit to: $_____.

Allow at least 24-hours for limits to be raised.

☐ Increase ATM withdrawal debit card limit to: $_____.

Increase for ATM withdrawals are based on the amount of your available balance at the time of request.

Please raise my VISA Check Card limit to the amount specified above. I understand that my account will be closely monitored. If abuse is detected, I am aware that my card will default to its original limits and/or my VISA Check Card privileges may be revoked. I understand that AdventHealth Credit Union is not responsible for any fees incurred by authorized merchants.

_____ _____

Cardholder Signature Date

FOR INTERNAL USE ONLY

Requested via: ☐ Phone ☐ In-Person ☐ Other _____	
Available Checking Account Balance $_____	Negative Balance in past 12 Months ☐ Y ☐ N ***(For Permanent Limit Increase only)***
Submitted by: **Teller # _____** **Initial _____** **Date _____**	
To be completed by Accounting/ Processing Officer:	
APPROVED ☐ One Time Limit Increase to: $_____ ☐ Permanent Limit Increase to: $_____	**DENIED** ☐ Negative Balance in past 12 Months ☐ Account Currently negative ☐ Current Balance doesn't justify raise ☐ Other: _____
Processed By: **Teller # _____** **Initial _____** **Date _____**	