



VISA CREDIT CARD BALANCE TRANSFER REQUEST

Name: _____ AHCUC Visa Credit Card #: _____ AHCUC # _____

Balance Transfer Rates: **Platinum: 9.99% APR**
 Classic: 14.99% APR
 Share Secured: 16.00% APR

Terms and Conditions:

1. If the balance transfer information provided is incomplete, AdventHealth Credit Union will not be able to process the request. Transfers will be sent to only recognized creditors or financial institutions and will not be sent to your home or billing address.
2. Balance transfers and/or cash advances may not be used to pay-off or pay down any AdventHealth Credit Union account.
3. Please continue to make your minimum payment until the requested transfer payment appears on the account's billing statement. AdventHealth Credit Union is not responsible for any remaining balance on that account, or for any finance or other charges you incur due to delays in transferring a balance.
4. If you transfer an amount for a transaction you dispute, you may lose some or all your rights against the other creditor.
5. While AdventHealth Credit Union can pay your accounts directly, it cannot close them for you. If you wish to close any of the transfer accounts, you must do so yourself.
6. Account balance transfers are contingent upon account setup and assigned credit limit. In some cases, AdventHealth Credit Union may not be able to process a balance transfer request.
7. Send the completed balance transfer request to:

AdventHealth Credit Union
Credit Card Processing
115 Boston Ave. Ste. 2400
Altamonte Springs, FL 32701
407.303.5700 EXT. 4013 | 407.303.0918 FAX

List all Creditor Payoff Information to be included in this Balance Transfer Request

FINANCIAL INSTITUTION: _____

ACCOUNT NO: _____

PAYOFF ADDRESS: _____

AMOUNT: \$ _____

FINANCIAL INSTITUTION: _____

ACCOUNT NO: _____

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AMOUNT: \$ _____

FINANCIAL INSTITUTION: _____

ACCOUNT NO: _____

PAYOFF ADDRESS: _____

AMOUNT: \$ _____

FINANCIAL INSTITUTION: _____

ACCOUNT NO: _____

PAYOFF ADDRESS: _____

AMOUNT: \$ _____

I authorize AdventHealth Credit Union to pay on my behalf, each balance or portion of balance I have designated. I have read the terms and conditions regarding this transfer request.

Signature: _____

Date: _____

Phone: _____

Email: _____

Internal Office Use Only

Date Received: _____ **Date Processed:** _____ **Processed By:** _____