

REQUEST FOR AUTOMATIC CREDIT CARD PAYMENT

 I hereby request the following change(s) to my **USALLIANCE** Visa credit card ending in (last 4 digits only): _____

Please schedule automatic monthly payments from my (please check one):

 Checking Account #: _____

 Savings Account #: _____

Routing #: _____ Institution Name: _____

Select one of the following payment options:

 Minimum Payment Due each month*

 Balance in Full*

 Fixed Amount*: \$ _____

 Please cancel my existing automatic payment

*It can take up to 1 billing cycle before automatic payments begin/end.

I understand and agree that this change is voluntary and that I remain obligated to pay all accrued finance charges each month regardless of the scheduled payment; that all payments remain due on the scheduled payment date; that this request is subject to final approval in accordance with Credit Union policy.

 Member Name (Printed)

 Member Number

 Member Signature

 Date

 Daytime Phone Number

Please return your completed form by

Mail: USALLIANCE Financial
 411 Theodore Fremd Avenue, Suite 350
 Rye, NY 10580-1410
 Attn: Payment Solutions

Email: memberservices@usalliance.org

Fax: (914) 462-3530

FOR CREDIT UNION USE	Processed by:	Date:
	Maint Crd/Mgr. Review:	Date: