(213) 748-4788 | fax (213) 742-0909 | info@lahfcu.org

LA Healthcare
Federal Credit Union

AUTHORIZATION TO CLOSE ACCOUNT

This letter authorizes LA Healthcare Federal Credit Union to the following:
(Please initial each item)

Account Number(s): _____

_____ Return of all ELECTRONIC FUNDS transfers, deposits, and withdrawals

_____ Return ALL checks

_____ Removal from ALL VISA Credit Cards

_____ Return of all ATM and VISA Debit cards
(All preauthorized transactions will require members to update information with merchants)

_____ Removal of Online Banking Access

_____ Removal of 24-Hour Accountline Access

By signing below, I/we agree that the account will be closed and I/we have read and understand the action items above.

_____ _____
Authorized Primary Member Signature Date

_____ _____
Authorized Joint Owner Signature Date

Credit Union Use Only	
Credit Union Staff:	Date
Comments:	