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

LA Healthcare
Federal Credit Union

WIRE TRANSFER FORM

You authorize us, LA Healthcare Federal Credit Union, to transfer funds as shown on the Wire Transfer Request Form. Our charges and fees for funds transfer are disclosed in our fee schedule. Other financial institutions involved in the funds transfer may impose additional charges. We may fail to act or delay in acting on a payment order without any liability because of legal constraint, your negligence, interruption of communication facilities, equipment failure, war emergency conditions, or other circumstances beyond our control. We may also fail to send or delay in sending a payment order without any liability if sending the order would violate any guideline, rule or regulation of any government authority. We are not liable for consequential, special or exemplary damages or losses of any kind. You have no right to cancel or amend this payment order. If you ask us to cancel or amend it, we may make a reasonable effort to act on your request but we are not liable to you if for any reason this payment order is not amended or canceled. You agree to reimburse us for any costs, losses or damages that we incur in connection with your request to amend or cancel the payment order. If we try to cancel this funds transfer, we do not have to refund your money until we determine that the beneficiary has not received the money and the money is returned to us. If we return your money, the refund may not be equal to the amount of the original payment order. The amounts may differ because of charges other banks may impose to return the funds transfer. We have cutoff times for processing payment orders. Orders received prior to 1:00 p.m. (Pacific Time) will be transmitted the same Day. If you give us this payment order after the cutoff Time, we may treat the payment order as if we received it on our next business day. Funds transfer business days will include all normal business days of L.A. Healthcare Federal Credit Union. You must accurately identify beneficiaries of your payment order. If you give us the name and account number of a beneficiary, we and other financial institutions may process the payment order based on the account number alone, even though the member may identify a person other than the beneficiary named. If you give us the name and identifying number of a financial institution, we and other financial institutions may process the payment order based on the identifying number alone, even though the number may identify a financial institution other than the financial institution named. In these cases, you are still obligated to pay us the amount of the payment order. If any part of the funds transfer is carried by Fedwire, your rights and obligations regarding the funds transfer are governed by Regulation J of the U.S. Federal Reserve Board. You authorize LA. Healthcare Federal Credit Union to debit your account to pay for this funds transfer. We notify you about the funds transfer by listing it on your account statement. You must send us written notice, including a statement of relevant facts within 14 calendar days after you receive the first account statement on which any unauthorized or erroneous debit to your account, or any other discrepancy between your record and ours appear. If you fail to notify us within this 14-day period, we are not liable or obligated to compensate you for any loss of interest or interest equivalent because of an unauthorized or erroneous debit.

SENDER INFORMATION

Member Name: _____

Member Account #: _____ Share Type: _____

Phone: _____ Email: _____

Signature: _____

Date: _____

RECEIVER INFORMATION

Amount: _____ Fee: _____

Wire To: *(Receiving Institution Name)* _____

ABA/Routing #: _____

Further Credit To: *(Correspondent Institution)* _____

Account #: *(Correspondent Institution)* _____

Final Credit To: *(Beneficiary)* _____

Account #: *(Beneficiary)* _____

Address: *(Beneficiary)* _____

City: _____ State: _____ Zip: _____

Other Reference: _____

PLEASE FAX COMPLETED FORM TO: (213) 742-0909

Credit Union Use Only

Date Received: Time Received: Employee Name:

Member Identified By:
☐ Mother's Maiden Name ☐ PIN # ☐ Telephone Call Back
☐ Password ☐ Last Transaction ☐ DL # _____

Accounting Sender: Accounting Verifier: Accounting Time & Ref #

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LA Healthcare
Federal Credit Union

WIRE TRANSFER INSTRUCTIONS

RECEIVING FINANCIAL INSTITUTION:

Catalyst Corporate FCU

Routing Number: 311990511

BENEFICIARY FINANCIAL INSTITUTION:

Los Angeles Healthcare Federal Credit Union

Account Number: 322078011

FINAL BENEFICIARY:

Member Name: _____

Account #: _____

Credit Union Use Only	
Credit Union Staff:	Date
Comments:	