

CHIROPRACTIC FEDERAL CREDIT UNION

Close Account Request Form

Financial Institutions Name: _____

Address: _____

City: _____ State: _____ Zip: _____

To Whom It May Concern:

Please accept this letter as authorization to close account number _____ at your institution and send a check for the remaining balance to me at my address below.

I understand that I will need to verify that all outstanding payments and deposits have cleared before the account is closed. I have already made arrangements to switch any automatic debits and deposits I have associated with this account.

If you have any questions, please contact me at (_____)_____.

Thank you,

Owner's Signature _____

Printed Name _____ Date _____

Joint Owner's Signature _____

Printed Name _____ Date _____

Mailing Address:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____



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