Broward HealthCare Federal Credit Union Membership and Services Application

Please select one

☐ **OPEN A NEW ACCOUNT**
A minimum deposit is required with a new account application

☐ **CHANGE EXISTING DATA**
This form will supersede any others on file. It must be completed in its entirety as if for a new account

LAST NAME	FIRST NAME	INITIAL	MEMBER NUMBER

STREET ADDRESS (WHERE YOU RESIDE-MUST MATCH ID)	CITY	STATE	ZIP

MAILING ADDRESS (WHERE YOU WANT YOUR MAIL SENT)	CITY	STATE	ZIP

PRIMARY PHONE NUMBER (HOME/CELL)	SECONDARY PHONE NUMBER (HOME/CELL)	WORK PHONE NUMBER / EXT.	DRIVERS LICENSE # / STATE

EMPLOYER NAME - ADDRESS	ELIGIBILITY-DEPARTMENT-FACILITY

SOCIAL SECURITY NUMBER	**Tin Certification and Backup Withholding Information - By signing below, under penalty of perjury, certify that: 1) The number shown on this form is my correct taxpayer identification number, 2) I am not subject to back up withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3) I am a U.S. person (including a U.S. resident alien).** Certification Instructions: Cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return. Cross out item 3 and complete form W-8 BEN if you are not a U.S. Person.
DATE OF BIRTH	

E-MAIL ADDRESS	SECURITY CODE WORD	HOW DID YOU HEAR ABOUT US?

JOINT OWNER (LAST NAME, FIRST, INITIAL)	DATE OF BIRTH	SOCIAL SECURITY NO.	DRIVERS LICENSE #/STATE
ADDRESS		Phone No:	

JOINT OWNER (LAST NAME, FIRST, INITIAL)	DATE OF BIRTH	SOCIAL SECURITY NO.	DRIVERS LICENSE #/STATE
ADDRESS		Phone No:	

ACCOUNTS OR SERVICES REQUESTED *Please check each account or service you are requesting with Broward HealthCare Federal Credit Union. MEMBERSHIP AND ACCOUNTS ARE SUBJECT TO APPROVAL. *RESTRICTIONS APPLY*

❑ **MEMBERSHIP** (Share Savings) *REQUIRED* ❑**ATM/VISA DEBIT CARD**

❑**CHECKING ACCOUNT** (*Choose one)* ❑**REWARDS** ❑**CLASSIC** ❑**ADVANTAGE** ❑**PARTNERSHIP***

❑**MONEY MARKET** ❑**CLUB ACCOUNT (NAME:_____)**

❑**YOUTH ACCOUNT** ❑**StarSaver(Birth-12 years)**
❑**MyMoney (13-18 years)** □ *Checking* □*MasterCard* □*ATM/VISA Debit*

(Initial One) **DESIGNATION OF PAY ON DEATH (POD) BENEFICIARY**

_____SINGLE-PARTY ACCOUNT-*At death of the party, ownership passes as part of the party's estate*

_____SINGLE-PARTY ACCOUNT WITH POD DESIGNATION -*At death of the party, ownership passes to the designated POD beneficiaries and is not part of the party's estate. (name one or more beneficiaries below.)*

_____MULTIPLE-PARTY ACCOUNT WITH RIGHT OF SURVIVORSHIP-*At death of the party, ownership passes to the surviving party or parties.*

_____MULTIPLE-PARTY WITH RIGHT OF SURVIVORSHIP AND POD DESIGNATION -*At death of the last surviving party, ownership passes to the designated POD beneficiaries and is not part of the last surviving party's estate. (Name one or more beneficiaries below.)*

POD PAYEE/BENEFICIARY RELATIONSHIP SOCIAL SECURITY NUMBER DATE OF BIRTH

COMPLETE ADDRESS (STREET, CITY, STATE AND ZIP)

POD PAYEE/BENEFICIARY RELATIONSHIP SOCIAL SECURITY NUMBER DATE OF BIRTH

COMPLETE ADDRESS (STREET, CITY, STATE AND ZIP)

PLEASE READ CAREFULLY BEFORE SIGNING:

I/We, the undersigned, apply to Broward HealthCare Federal Credit Union for membership in the Credit Union and for the accounts and/or services listed on the reverse side. By signing below, I/We agree to the Terms and conditions of the Membership and Account Agreement contained in the Membership Booklet, Truth In Savings, Rate and Fee Schedules, Funds Availability Policy Disclosure, if applicable, and to any amendment the Credit Union makes from time to time which are incorporated herein. I/We acknowledge receipt of a copy of the Account Agreement and disclosures and fee schedule applicable to the accounts and services requested herein. If an access device or EFT service is requested and provided. I/We agree to the terms and acknowledge receipt of the Electronic Funds Transfer Agreement and Disclosure.

I/We agree that the Credit Union is authorized to recognize any of the signatures subscribed below for the transaction of any business on any account on which that party is named as an owner; that all funds in any account shall be considered as being held by each owner;

By signing below I/we authorize the Credit Union to check my credit, account, and employment history, and to obtain reports from third parties, including credit reporting agencies, to verify eligibility for the accounts and services you request. Copies of my pay-stub may be required. I understand that you may contact me for further information, and that this application must be completed fully for the Credit Union to process my request.

I understand that by signing this form I am verifying my membership eligibility.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

X_____

SIGNATURE OF OWNER/MEMBER **DATE**

X_____

SIGNATURE OF JOINT OWNER **DATE**

X_____

SIGNATURE OF JOINT OWNER **DATE**

THIS FORM MUST BE WITNESSED BY A CREDIT UNION OFFICIAL OR NOTARIZED BELOW.

_____

SIGNATURE OF CREDIT UNION EMPLOYEE OPENING ACCOUNT

THE FOREGOING INSTRUMENT WAS ACKNOWLEDGED BEFORE ME THIS _____DAY OF _____,_____ BY_____

WHO IS PERSONALLY KNOWN TO ME OR WHO HAS PRODUCED _____AS IDENTIFICATION.

_____ _____ **STAMP:**

SIGNATURE OF NOTARY **DATE**

_____ _____

PRINTED NAME OF NOTARY **EXPIRATION**

FOR CREDIT UNION USE ONLY

		Owner	Joint Owner	Beneficiary(s)
CHEXSYSTEMS INFO _____	**OFAC:** Pass:	☐	☐	☐
_____	Override:	☐	☐	☐

CREDIT REPORT SCORE _____ **ELIGIBILITY VERIFIED** _____ **IDENTIFICATION:** ☐ Copied ☐ Scanned

ACCT OPENED BY: _____ **DATE** _____

(MSR First Initial/Last Name)