Debit Card Application

Applicant

Account Number _____
Name _____
Address _____
City _____
State _____ Zip _____
Home Phone # _____
Social Security # _____
Date of Birth _____
Employer _____
Mother's Maiden Name _____

Co - Applicant

Account Number _____
Name _____
Address _____
City _____
State _____ Zip _____
Home Phone # _____
Social Security # _____
Date of Birth _____
Employer _____
Mother's Maiden Name _____

Signatures: By signing below, the undersigned request the described service and agrees to the terms and conditions governing the service, including any fees and charges. The undersigned agrees that all information is accurate and authorizes the financial institution to verify credit and employment history by any necessary means, including preparation of a credit report by a credit reporting agency. **In addition, the undersigned acknowledges by his/her signature that the debit card will be permanently blocked if two or more debit transactions are presented for payment and funds are not available for paying the transaction. The credit union does extend the courteous time of 10:00am, on the same banking day, for the funds to be deposited into the members account.**

Applicant Signature _____
Date _____
Co-Applicant Signature _____
Date _____

Acadiana Medical
Federal Credit Union
702 Saint Landry Street
Lafayette, LA 70506

Official Use Only:
Date received _____
Approved (Y/N) _____
Processed By _____