

HealthNet Federal Credit Union

Debit Card Application

Account # _____

Primary Owner Information:

Name _____

Street _____

City/ _____

State/Zip _____

Home _____

Phone _____

Work _____

Phone _____

Joint Owner Information

Name _____

Street _____

City/ _____

State/Zip _____

Home _____

Phone _____

Work _____

Phone _____

By signing below, you certify that the information on this application is complete, true, and submitted for the purposes of obtaining the electronic service(s) and account(s) requested. If approved for the requested electronic funds transfer services, you acknowledge receipt of and agree to the terms of the Electronic Transfer Agreement.

Primary Owner Signature Date

Joint Owner Signature Date

Date Received

Date Processed

RETURN BY FAX TO: (901) 226-1122