HEALTH CENTER CREDIT UNION

Credit Card Application

VISA

1424 Walton Way
Augusta, GA 30901
(706) 434-1600
(800) 472-3272

HEALTH CENTER Credit Union	
ANNUAL PERCENTAGE RATE for Purchases	9.9%** up to 18.0%** When you open your account based on creditworthiness
ANNUAL PERCENTAGE RATE for Balance Transfers	9.9%** up to 18.0%** When you open your account based on creditworthiness
ANNUAL PERCENTAGE RATE for Cash Advances	9.9%** up to 18.0%** When you open your account based on creditworthiness
How To Avoid Paying Interest on Payments	Your due date is at least 25 days after the close of each billing cycle. We will not charge you interest on purchases if you pay your entire balance by the due date each month.
Penalty APR and When it Applies	18.0% This APR may be applied to your account if you: Make a late payment; Go over your credit limit twice in a six-month period; Make a payment that is returned; or Do any of the above on another account that you have with us. **How long will the Penalty APR Apply?:** If your APR's increased for any of these reasons, the Penalty APR will apply until you make six consecutive minimum payments when due and do not exceed your credit limit during that time period.
For Credit Card Tips From the Consumer Financial Protection Bureau	To learn more about factors to consider when applying for or using a credit card, visit the website of the Consumer Financial Protection Bureau at: http://www.consumerfinance.gov/learnmore
FEES	
Cash Advance Fee	$ 5.00
Transaction Fees	1% of transaction amount/foreign
Penalty Fees Late Payment Returned Payment Fee	Up to $35.00 Up to $35.00

How We Will Calculate Your Balance: We use a method called "Average Daily Balance (including new purchases)".
See your account agreement for more details.
Billing Rights: Information on your rights to dispute transactions and how to exercise those rights is provided in your Account agreement.
**ANNUAL PERCENTAGE RATE is based on individual Credit History. The information about the costs of the card as described in the application is accurate as of October, 2020. The information may have changed after that date. For changes since printed call or write to us at the number or location shown on the reverse.

CREDIT UNION USE ONLY

Credit Card Limit $ Approved on No. of Cards Issued:

Gold Club _____ E-Checking _____

SPECIFIC REASON (S) FOR REJECTION

OUTSIDE INFORMATION CONSIDERED? ☐ YES ☐ NO IF YES, ATTACH ADDITIONAL SHEET AND DESCRIBE

COMMENTS:

LOAN OFFICER SIGNATURE:

X

ECOA NOTICE AND REASON FOR REJECTION SENT OR DELIVERED ON: (DATE) BY (INITIALS)

TRANSFER OF BALANCES FROM OTHER LENDER(S):

Balances owed on other credit card accounts, department stores or other financial institutions may be transferred to your Health Center Credit Union card account. Please transfer my existing balance(s) as instructed below to my new Health Center Credit Union credit card account. Health Center Credit Union will pay the amount(s) indicated below upon approval, however some additional finance charges and account purchases may accrue on your old account(s) during the process. Please continue to maintain payments on these account while we are processing your balance transfer requests. All transfer requests will be made in the priority as requested below up to my available credit limit.

A Copy of the Most Recent Statement is Required

LENDER NAME AND ADDRESS	ACCOUNT NO.	EXACT AMOUNT TO BE PAID (Do not write "all" or "in full")

Please list any additional requests on an attached sheet.

Health Center Credit Union may advance the total amount indicated above (not to exceed 90% of my Health Center Credit Union VISA limit) from my credit card account(s) indicated above to my Health Center Credit Union card account. If the request for payment(s) exceeds 90 percent of my credit limit, I understand that Health Center Credit Union reserves the right to pay all or part of the balance(s) above. I also understand that this payment will not close my non-Health Center Credit Union credit card account(s), and I need to notify the credit card company to return my credit cards(s).

I authorize you to charge my Health Center Credit Union credit card account for the total amounts indicated above. I understand you will advise me if you are unable to process this payment request for any reason. I also understand that Health Center Credit Union cannot close my account(s) with other lenders and is not responsible for any additional charges billed to me on any account listed above or on an attached sheet.

PRIMARY CARDHOLDER _____ JOINT CARDHOLDER _____ DATE _____

HEALTH CENTER CREDIT UNION

APPLICATION FOR CREDIT CARD

Maximum Credit Limit $_____

NOTICE: The information below and on the reverse will be used to evaluate your credit request. If this will be a joint account the co-applicant must sign where indicated. Married persons may apply for an individual account. This account will be:

☐ INDIVIDUAL ACCOUNT ☐ JOINT ACCOUNT ☐ CO-APPLICANT ☐ INDIVIDUAL ACCOUNT WITH AUTHORIZED USER

PLEASE PRINT — PLEASE ANSWER ALL QUESTIONS

Applicant (Member)

Full Name			Social Security No.	Date of Birth	Cell Phone
Street Address	City/State	Zip	Years There	☐ Own ☐ Rent $_____	Home Phone
Previous Address - If less than two years at present address			Years There	☐ Own ☐ Rent $_____	Driver's License No.
Mailing Address - If Different				Email	
Present Employer			Position	Starting Date	Business Phone
Previous Employer	Address		Position	Starting Date	Date of Separation
Name and Address of Nearest Realative Not Living With You			Gross Monthly Income $	For Security Purposes — What Is Your Mother's Maiden Name?	

(To be completed if you reside in a community property state - AK, AZ, CA, ID, LA, NM, NV, PR, TX, WA, WI - or if you are applying for joint credit)

☐ Married ☐ Separated ☐ Unmarried (single, divorced, widowed)

Income from Alimony, Child Support or Separate Maintenance income, need not be revealed if you do not wish to have it considered as a basis for repaying this obligation.

Other Income

Other Income	Source	Monthly Income $

Complete this section if this will be a joint account, authorized user account, or if you are relying on income of another person in order to repay the credit. Other person must sign below.

Spouse / Joint Applicant

Full Name			Social Security No.	Date of Birth	Cell Phone
Street Address	City/State	Zip	Years There	☐ Own ☐ Rent $_____	Home Phone
Previous Address - If less than two years at present address			Years There	☐ Own ☐ Rent $_____	Driver's License No.
Mailing Address - If Different				Email	
Present Employer			Position	Starting Date	Business Phone
Previous Employer	Address		Position	Starting Date	Date of Separation
Name and Address of Nearest Realative Not Living With You			Gross Monthly Income $	For Security Purposes — What Is Your Mother's Maiden Name?	

(To be completed if you reside in a community property state - AK, AZ, CA, ID, LA, NM, NV, PR, TX, WA, WI - or if you are applying for joint credit)

☐ Married ☐ Separated ☐ Unmarried (single, divorced, widowed)

Income from Alimony, Child Support or Separate Maintenance income, need not be revealed if you do not wish to have it considered as a basis for repaying this obligation.

Other Income

Other Income	Source	Monthly Income $

CREDIT INSURANCE DISCLOSURE

Credit Life and/or Credit Disability Insurance is not required to obtain credit under this plan and will be included only if requested immediately below by the APPLICANT(S). The insurance rates are shown below. Each month the insurance charge is calculated by multiplying the total of outstanding principal balance by the rate shown. You must be under age 70 for life insurance. You must be under age 65 for disability insurance and you must be actively at work full time for wages or profit and you must be physically present at work for at least 30 hours for each of the 2 consecutive weeks prior to each new loan or line of credit for the insurance to take effect. Joint Life coverage covers the Applicant and the Co-Applicant. Your Co-Applicant is not eligible for Disability Insurance. If Coverage is selected and you are eligible, you will be charged a premium and given a Certificate of Insurance from Transamerica Life Insurance Company, which provides the important terms of this coverage. Read it carefully. If you do not check "Yes" below, no coverage will be added nor in force. This insurance product is not insured by an agency of the federal government and the insurance is not guaranteed by the Credit Union.

COVERAGES SELECTED

☐ YES ☐ NO Single Credit Life at a cost of $.55 per $1,000 of your monthly VISA balance

☐ YES ☐ NO Joint Credit Life at a cost of $.88 per $1,000 of your monthly VISA balance

☐ YES ☐ NO Credit Disability at a cost of $2.20 per $1,000 of your monthly VISA balance (Primary Borrower Only)

If you applied for Credit Insurance, You authorize Us to add the required premiums to Your Account, charge a finance charge on the premiums at the rate which applies to Your Account, and forward such premiums to the Insurance Company.

X _____ Proposed Insured Signature DATE

X _____ Joint Proposed Insured Signature DATE

AUTHORIZED USERS:
State the name and relationship to you of every person who will be authorized to use your card account. These individuals are authorized to make charges on your account but are not liable for payment.

Authorized User S.S.#_____ Date of Birth_____ Phone No._____

ADDITIONAL CARD FOR AUTHORIZED

USER:_____

AUTHORIZED USER NAME TO APPEAR ON THE CARD

READ THESE STATEMENTS BEFORE YOU SIGN

AS A CONDITION FOR THE APPROVAL OF THIS CREDIT CARD ACCOUNT, YOU GIVE US A SPECIFIC PLEDGE OF YOUR CREDIT UNION SHARE ACCOUNT AS SHOWN BELOW AS SECURITY FOR THE ACCOUNT. YOU ARE NOT GIVING US A SECURITY INTEREST IN ANY DEPOSIT ACCOUNT THAT WOULD HAVE ADVERSE TAX CONSEQUENCES IF PLEDGED AS SECURITY. YOU UNDERSTAND THAT YOU WILL NOT HAVE ACCESS TO PLEDGED AMOUNTS FOR AS LONG AS YOUR CREDIT ACCOUNT IS OPEN.

Share Acct. No. _____ **Amount Pledged $** _____

X SIGNATURE OF APPLICANT DATE

X SIGNATURE OF CO-APPLICANT DATE

The Ohio laws against discrimination require that all creditors make credit equally available to all credit worthy customers and that credit reporting agencies maintain separate credit histories on each individual upon request. The Ohio civil rights commission administers compliance with this law.

All information that you have stated in this application is correct to the best of your knowledge. The Credit Union is authorized to check your credit, employment history, obtain a credit report and to answer questions about your credit experience with us. You authorize us to disclose information regarding your account as permitted and/or required by law or to effect, administer or enforce a transaction. You agree that once this application is submitted, it will become the property of Health Center Credit Union whether or not the loan is approved. You understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements concerning any of the above facts as stated under the provisions of the United States Criminal Code. You shall be liable and agree to pay issuer for Card Purchases made by, or for Loans extended to, you or anyone else using such card unless the use of such card is by a person other than you (a) who does not have actual, implied or apparent authority for such use; and (b) from which you received no benefit. Additionally, you shall be jointly and severally liable and agree to pay for all Credit Purchases and Loans obtained through the use of any other Card bearing your account number that has been issued to another person by reason of such person being a member of your family, or otherwise issued upon Cardholder's request (all such Cards bearing the same credit card account number.) You acknowledge and agree that the Credit Union's VISA Department may terminate the agreement under the following conditions: 1. Under adverse re-evaluation of your credit worthiness; 2. Upon your failure to satisfy the terms of the agreement; 3. At your option or the Credit Union's option if it has good cause. If line of credit is to be terminated by the Credit Union, you shall receive written notice of such termination. However, you understand and acknowledge that such termination shall not affect your obligation to pay any outstanding balance.

By signing the Credit Card application, you realize that you are bound by the terms and conditions as set forth in Health Center Credit Union's terms and conditions in effect, which will be furnished to you with your card. Required rate disclosures are provided on the reverse. Any special introductory rate is disclosed as an attachment to this form.

X SIGNATURE OF APPLICANT DATE

X SIGNATURE OF CO-APPLICANT DATE