Viriva
Community Credit Union
Your financial partner… for life.

Name(s):_____

Member #:_____

MasterCard® Acct#:_____

Request Increase in MasterCard® Line of Credit

Desired Credit Limit:_____

Daytime Phone #:_____

Please attach a copy of your most recent pay stub(s) or W-2(s).

By signing below, you authorize Viriva Community Credit Union to obtain credit reports in connection with this application for a credit increase.

_____ _____

Member Signature Date Member Signature Date

Transfer Other Card Balances

I hereby authorize Viriva Community Credit Union to pay the "Amount" indicated to the "Card Issuer" shown by issuing a check and adding the "Amount" to my Viriva Community Credit Union MasterCard® Platinum *Preferred* Credit Card Account. I understand that the amount transferred, combined with my current balance, and cannot exceed my current credit limit.

Card Issuer:_____

Address:_____

Account#:_____

Pay this Amount:_____

_____ _____

Member Signature Date Member Signature Date

Please note that for NEW accounts, a Balance Transfer cannot be processed until after you have activated your account/card. This form may be copied if you have more than one (1) account you wish to transfer. The Balance transfer fee is 3%, with a $5.00 minimum, no maximum.

Return the completed form by mail to: 157 York Road, Warminster PA 18974.
You can also fax it to 267-803-8390.