345 S. Magnolia Dr., Suite F-1
Tallahassee, FL 32301
Fax: 850-402-5334

tmH federal credit union

AUTOMATIC TRANSFER AUTHORIZATION

Name:	**Member Account Number:**
Address:	
City, State, Zip:	
Home Phone:	**Work Phone:**
Email Address:	**Cell Phone:**

☐ New ☐ Update ☐ Cancel

I authorize TMH Federal Credit Union to transfer funds from my account(s) as follows:

Frequency: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

Beginning Date:_____

Amount:	**From Account:**	**To Account/Suffix:**

I understand it is my responsibility to maintain a balance in my account to enable the transfer to be made on the specified date. If there are not sufficient funds in the account on the transfer date, available funds will be used to make a partial transfer in any order determined by TMH Federal Credit Union. The transfers will continue until I notify the Credit Union in writing to cancel or update the transfer or if the Credit Union notifies me the transfer will be discontinued. The Credit Union must receive the written request for cancellation seven (7) business days prior to the transfer.

_____ _____

Member Signature **Date**

Internal Use Only	Sent/Requested Via: ☐ Mail ☐ Facsimile ☐ In Person	
_____	_____	_____
Date Received	Date Entered	Employee Initials and Teller No.