

## Automatic Transfer Authorization

PRIMARY MEMBER NAME: \_\_\_\_\_

JOINT MEMBER NAME: \_\_\_\_\_

ACCOUNT NUMBER TO DEBIT: \_\_\_\_\_

RECEIVING ACCOUNT NUMBER: \_\_\_\_\_

AMOUNT: \_\_\_\_\_

COMMENCEMENT DATE: \_\_\_\_\_

FREQUENCY:

Monthly	<input type="checkbox"/>
Weekly	<input type="checkbox"/>
Bi Weekly	<input type="checkbox"/>
Yearly	<input type="checkbox"/>

AUTHORIZATION NUMBER  
(for office use only): \_\_\_\_\_

PLEASE DEDUCT THE ABOVE AMOUNT UNTIL FURTHER NOTICE.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

**(For Office Use Only)**

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Receiving Branch

**Please return to:**  
Teachers Federal Credit Union  
PO Box 9005  
Smithtown, NY 11787-9005  
Attention: Member Services Department  
FAX: 631 648-2045  
E-mail: [webmail@teachersfcu.org](mailto:webmail@teachersfcu.org).