



**VISA CLASSIC CREDIT CARD
APPLICATION**

APPLICANT INFORMATION

_____ **YES...I want to apply for a Foothills Federal Credit Union VISA Credit Card.**

Name (as it should appear on card): _____

Mother's Maiden Name: _____

Applicant's Social Security #: _____ Birth Date: _____

Mailing Address (City, State Zip): _____

of Cards: _____ Limit Request: _____

Applicant Employer: _____ Date Employed: _____

Annual Income: _____ Mortgage Payment or Rent: _____

CO-APPLICANT INFORMATION

Co-Applicant's Name: _____

Mother's Maiden Name: _____

Co-Applicant's Social Security #: _____ Birth Date _____

Co-Applicant Employer: _____ Date Employed _____

Annual Income: _____

We may report information about your loan and deposit accounts to credit bureaus. Late payments, missed payments, or other defaults on your accounts may be reflected in your credit report.

PLEASE READ, SIGN, AND DATE REQUEST FORM

I hereby certify that all statements made are true and submitted for the purpose of obtaining credit, whether completed by me or the Credit Union at my direction. In considering this application, the Credit Union may request the use of a report from outside credit reporting agencies. They may ask a reporting agency for other such reports in connection with renewal or continuation of the credit for which I am applying. Upon request the Credit Union will supply the name and address of the credit bureau providing such information. I acknowledge notice of this disclosure. If the application is approved and the Visa card(s) issued, I (we) agree by signing, using the permitting another to use the card(s) to be bound by the Cardholder Agreement mailed under separate cover. See below for Credit disclosures.

TABULAR DISCLOSURE

Annual Percentage Rate (APR) for Purchases	Other APR's*	Grace Period for Purchases	Method of Computing the Balance for Purchases	Annual Fee	Minimum Finance Charge
VISA Classic 8.00%-15.00%*	Cash Advance APR 8.00% - 15.00% Balance Transfer APR 8.00% - 15.00%	25 days	Average Daily Balance (Including new purchases)	None	None

Transaction Fee for Purchases..... None	Late Payment Fee..... \$25.00
Balance Transfer Fee..... None	Return Check Fee..... \$25.00

*The **ANNUAL PERCENTAGE RATE** is based on certain credit-worthiness criteria.
 The information about the costs of the card described in this application is accurate as of 8/27/2010. This information may have changed after that date. To find out what may have changed, contact the credit union.

Applicant's Signature: _____ Date: _____

Co-Applicant's Signature: _____ Date: _____

CREDIT INSURANCE APPLICATION/SCHEDULE

"You" or "Your" means the member and the joint insured (if applicable).

Credit insurance **is voluntary and not required in order to obtain this loan**. You may select any insurer of your choice. You can get this insurance only if you check the "yes" box below and sign your name and write in the date. The rate you are charged for the insurance is subject to change. You will receive written notice before any increase goes into effect. You have the right to stop this insurance by notifying your credit union in writing. Your signature below means you agree that:

- If you elect insurance, you authorize the credit union to add the charges for insurance to your loan each month.
- You are eligible for disability insurance only if you are working for wages or profit for 25 hours a week or more on the date of any advance. If you are not, that particular advance will not be insured until you return to work. If you are off work because of temporary layoff, strike or vacation, but soon to resume, you will be considered at work.
- You are eligible for insurance **up to** the Maximum Age for Insurance. Insurance will stop when you reach that age.

NOTE: THE LIFE AND DISABILITY INSURANCE CONTAINS CERTAIN BENEFIT EXCLUSIONS, INCLUDING A PRE-EXISTING CONDITION EXCLUSION. PLEASE REFER TO YOUR CERTIFICATE FOR DETAILS.

YOU ELECT THE FOLLOWING INSURANCE COVERAGE(S)	YES	NO	COST PER \$100 OF YOUR MONTHLY LOAN BALANCE
Single Credit Disability	_____	_____	\$25
Single Credit Life	_____	_____	\$08
Joint Credit Life	_____	_____	\$128

INSURANCE MAXIMUMS	DISABILITY	LIFE
Max. Monthly Total Disability Benefit	\$600	N/A
Max. Insurance Balance per Loan Account	\$30,000	\$30,000
Max. Age for Insurance	NONE	NONE

GROUP POLICY NUMBER ACCOUNT NUMBER

041-0457-5

If you are totally disabled for more than 30 days, then the disability benefit will begin with the 1st day of disability.

Secondary Beneficiary (if you desire to name one)

Member's Date of Birth

Joint insured's Date of Birth

X _____
Signature of Member
(Be sure to check one of the boxes above)

X _____
Signature of Joint Insured (Co-Borrower)
(Only required if Joint Credit Life coverage is selected)

Fax to:
(865) 458-1710