Close Account Request Form

CREDIT UNION ADVANTAGE
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Financial Institutions Name: _____

Address: _____

City: _____ State: _____ Zip: _____

To Whom It May Concern:
Please accept this letter as authorization to close account number _____ at your institution and send a check for the remaining balance to me at my address below.

I understand that I will need to verify that all outstanding payments and deposits have cleared before the account is closed. I have already made arrangements to switch any automatic debits and deposits I have associated with this account.

If you have any questions, please contact me at (_____)_____.

Thank you,

Owner's Signature _____

Printed Name_____ Date _____

Joint Owner's Signature _____

Printed Name_____ Date _____

Mailing Address:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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Providence Medical Building
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Southfield, MI 48075
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Novi Branch
Providence Park Medical Office Building
26850 Providence Parkway, Suite 110
Novi, MI 48374
248-662-0383 • Fax: 248-662-0385