LAHealthcare Federal Credit Union

Member Application

P: (213) 748-4788 | **F:** (213) 742-0909 | **E:** info@lahfcu.org

1 | ELIGIBILITY

I'm eligible to join LA Healthcare Federal Credit Union because I am (please check one): *subject to verification*

Employee of *(Eligible Organization)*

- ☐ **Dignity Health-California Hospital Medical Center**
- ☐ **PIH Health Good Samaritan Hospital**
- ☐ **St. Vincent's Meals on Wheels**
- ☐ **Relative of** (name) _____

(Must already be a member of LA Healthcare FCU)

2 | MEMBER INFORMATION

Primary Owner Name:							
Address:							
City:				*State:*		*Zip:*	
Yrs at Residence:		☐ *Rent* ☐ *Own* ☐ *Live with Family*		*DOB:*		*DL#*	
Social Security Number:			*Mother's Maiden Name:*				
Employer:		*Occupation:*			*Date of Hire:*		
Monthly Salary:		*Phone:*		*Email:*			

3 | JOINT OWNER INFORMATION

Primary Owner Name:							
Address:							
City:				*State:*		*Zip:*	
Yrs at Residence:		☐ *Rent* ☐ *Own* ☐ *Live with Family*		*DOB:*		*DL#*	
Social Security Number:			*Mother's Maiden Name:*				
Employer:		*Occupation:*			*Date of Hire:*		
Monthly Salary:		*Phone:*		*Email:*			

Pay-On-Death (Person 1): *In the event of my death, or if there is more than one owner, the death of all owners, I/we hereby designate as my/our Pay-on-death payee to receive all sums in my/our account established on this form.*

Name:		*Social Security Number:*	
Relationship:		*DOB:*	

Pay-On-Death (Person 2): *In the event of my death, or if there is more than one owner, the death of all owners, I/we hereby designate as my/our Pay-on-death payee to receive all sums in my/our account established on this form.*

Name:		*Social Security Number:*	
Relationship:		*DOB:*	

4 | CHOOSE SERVICE & INDICATE INITIAL DEPOSIT

(contact the Credit Union concerning Certificate Accounts)

☑ Membership Fee ($5.00) **$** 5.00 ☐ Regular Shares ($50.00 minimum deposit) **$** _____ **TOTAL ENCLOSED** **$** _____

5 | SOCIAL SECURITY NO. / TAXPAYER I.D.

Under penalties of perjury, I certify that: (1) The number shown on this form is my correct tax payer identification number; (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject backup withholdings as a result of a failure to report all interests or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. person (including a U.S. resident alien).

Instructions: Cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return. Cross out item 3 and complete a W-8 BEN if you are not a U.S. person.

6 | ACKNOWLEDGEMENT & SIGNATURE

I hereby make application for membership in and agree to be bound by the bylaws, regulations, policies, and rules, and any amendments thereof, of LA Healthcare Federal Credit Union. My signature below and use of the account will confirm my agreement to be bound and my acceptance of the Agreement on the reverse.

NOTE: The Internal Revenue Service does not require consent to any provision of this document other than the certifications required to avoid backup withholding.

_____ _____

Primary Owner Signature **Date (MM/DD/YYYY)**

_____ _____

Joint Owner Signature **Date (MM/DD/YYYY)**

Credit Union Use Only	ACCOUNT #	
Opened by		
Date		
ID		
ChexSystem		
Initial		
Approved		
Audited		