



## Courtesy Pay Application

Courtesy Pay is a service that may be added to your checking account. It covers checks and other authorized transactions when there are insufficient funds in your account, up to your pre-authorized limit.

I understand that I must have a Metro Medical Credit Union checking account open and in good standing and be participating in my employer's direct deposit program. My signature below acknowledges my agreement to the terms and conditions stated in the Credit Union's Membership and Account Agreement, Electronic Funds Transfer Agreement & Disclosure, and the Rate and Fee Schedule, which is incorporated into and made a part of this application and to any amendments the Credit Union makes from time to time.

By signing below, I understand that Metro Medical Credit Union will make every possible attempt to clear my authorized transaction(s). I understand that a transfer will only take place if the funds transferred are enough to cover my check and the Courtesy Pay fee of \$35.00. If sufficient funds are not available from my savings account, line of credit or pre-authorized Courtesy Pay limit, then the Credit Union has the right to return the item to the payee and charge my account a Non-Sufficient Funds (NSF) fee of \$35.00.

## Opt-In Application

Due to recent changes in legislation, called Regulation E, we are required to have all members **OPT-IN** (or choose) to receive and/or keep Overdraft Protection on their ATM and everyday debit card transactions. On or after August 15, 2010, we will no longer be able to cover these transactions unless you have "opted in". The rule does NOT apply to other types of transactions like paper checks; they will continue to be considered for payment.

By checking the "**Opt-In**" box and signing below you are authorizing us to pay overdrafts on ATM and everyday debit card transactions. There will be a fee of \$35.00 for each overdraft paid, up to your Courtesy Pay limit, and there is no limit on the total of fees we can charge for overdrawing your account.

**Opt-In** (YES! I WANT Metro Medical Credit Union to authorize and pay overdrafts on my ATM and everyday debit card transactions)

**Opt-Out** (No. I do not want Metro Medical Credit Union to authorize and pay overdrafts on my ATM and everyday debit card transactions)

I HAVE THE RIGHT TO REVOKE THIS COVERAGE AT ANY TIME BY CONTACTING THE CREDIT UNION IN WRITING.

Name on Account: \_\_\_\_\_

Account #: \_\_\_\_\_ Daytime Telephone #: \_\_\_\_\_

Primary Owner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Joint Owner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_