



[P] 214-630-0611
 [F] 214-688-7042
 www.mmcu.com

Outgoing Wire Transfer Form

Date: _____ Time: _____ Taken By: _____ Fee: \$ _____

Metro Medical Credit Union Member Information

Name: _____
 Account Number: _____ Phone Number: _____
 Amount to be Wired: _____ Debit My: Checking Savings
 Purpose of Payment: _____

Domestic Wire Transfers - \$25 Fee. Cut off time is 3:30 PM CST.

Credit to receiving Financial Institution:

Institution Name: _____ ABA/#: _____
 City: _____ State: _____ Zip: _____ Phone: _____

For further credit to:

Name of Person/Company Receiving: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Account Number: _____ Type of Account: _____
 Special Instructions: _____

International Wire Transfers - \$35 Fee. Cut off time is 2:00 PM CST.

Foreign Bank Information:

Swift/BIC Code: _____ IBAN #: _____
 Bank Name: _____
 Bank Address: _____
 City: _____ Country: _____

Beneficiary Information:

Name: _____ Account Number: _____
 Address: _____
 Special Instructions: _____

Western Union - \$25 Fee for Domestic. Cut off time is 4:30 PM CST.

Recipient's name must be **exactly** as it appears on their driver's license along with the city and state where the Western Union will be received. **Recipient must answer test question: "Who sent the money?" The answer is "CATALYST - Plano, Texas."**

Recipient Information:

First Name: _____ Middle Name: _____ Last Name: _____
 City: _____ State: _____

Member Signature: _____ Date: _____