



## VISA CHECK CARD AGREEMENT AND DISCLOSURE

This is your VISA Check Cardholder Agreement with Baptist Health South Florida Federal Credit Union. Please read it carefully and keep it for your records. All transactions made with your Card (hereafter referred to as the "Card") are also subject to the agreements that govern the checking account you choose to access with the Card. Please sign your Card immediately and activate it at an ATM machine. You do not have to sign this Agreement. Your agreement to all of these provisions will be confirmed by activating your Card, signing your Card, or using your Card, whichever occurs first.

**1. DEFINITIONS.** In this agreement, the "Card" means either one or more Baptist Health South Florida F.C.U. Cash and Check Cards; the words "you," "your," and "yours," mean the principle member as well as anyone the Cardholder permits to use the Card; the words "we", "us" and "our" refer to Florida Health Systems F.C.U.

**2. BUSINESS DAYS.** For the purposes of these disclosures, our business days are Monday through Friday. Holidays are not included.

**3. CARD USES.** You must sign the card in order to use it. You may use the Card to access your Baptist Health South Florida F.C.U. accounts in order to buy or lease goods (in person or by telephone), pay for services (in person or by telephone), or get cash from a merchant where the Card is honored by merchants displaying the VISA, PRESTO, PLUS, CU-24, MEMBER ACCESS, or THE EXCHANGE logos. These transactions are known as "point of sale" (POS) transactions. Also, you may use the card at any Florida Health Systems F.C.U. automated teller machine (ATM) that we may activate in the future and any ATM machines displaying the VISA, PRESTO, PLUS, CU-24, MEMBER ACCESS, or THE EXCHANGE logos or any other institution that accepts the Card. Use of the Card will directly access your checking account. At ATM machines you may make withdrawals, transfers and balance inquires on checking and saving accounts.\* This Card does not constitute a line of credit from us. You may not exceed \$1500.00 in transactions per day, plus, there is a \$500.00 daily withdrawal limit at ATMs. \* Some of these services may not be available at certain terminals.

**4. OVERDRAFT PROTECTION.** If you have overdraft protection, you specifically request that transfers be made to cover overdrafts that occur when using your Card. In the event that you withdraw amounts in excess of your balance(s) in your account(s), you hereby authorize Baptist Health South Florida F.C.U. to debit any of your account(s) (with the exception of IRA accounts) not overdrawn to cover your unauthorized withdrawal. The preceding policy applies to all accounts, including joint accounts.

**5. SECURITY MEASURES.** Florida Health Systems F.C.U. will issue you, under separate mailing, a PERSONAL IDENTIFICATION NUMBER (PIN) to be used with your Card. Use your PIN when making ATM transactions and, in some cases, when you conduct POS transactions. You agree not to write your PIN on your Card and not to carry your PIN with you at the same time as you carry your Card. You agree to use your best efforts to memorize your PIN. You will be responsible for all transactions made by you or by anyone you authorize/permit to use the Card. Do not divulge your PIN to any unauthorized person, not even a Baptist Health South Florida F.C.U. employee, either directly or indirectly, at any time. If you have forgotten your Card's PIN, please contact Baptist Health South Florida F.C.U.

**6. YOUR LIABILITY FOR UNAUTHORIZED TRANSFERS.** Notify us at immediately if you believe your Card and PIN have been lost, stolen or used without your permission. Contacting us by phone is the best way to keep your possible losses to a minimum. You could lose all of the available funds in your account (s). If you notify us within two business days, you can lose no more than \$50.00 if someone used your Card and/or PIN without your permission. If you do not notify us within two business days after learning of the loss or theft of your Card and /or PIN you could lose as much as \$500.00. Also, if your statement shows transactions that you did not make or authorize, notify us immediately. If you do not tell us with 60 days after the statement was mailed to you, you may not get any money you lost if we are able to prove that we would have stopped someone from taking your money if you would have told us in time. If a valid reason kept you from notifying us, we will extend the time period. If you believe your Card and /or PIN have been lost or stolen, or that someone has transferred or may transfer money from you account (s) without your permission, call (305) 662-8138, or write to: 6200 SW 73 ST, Miami, FL 33143 (South Miami Hospital branch). You can also contact us at (786) 596-5918, or write to: 8900 N Kendall Dr, Miami, FL 33176 (Baptist Hospital branch).

**7. STOP PAYMENT.** You do NOT have the right to make a stop payment on any POS transaction initiated with your Card.

**8. MONTHLY STATEMENT AND TERMINAL RECEIPTS.** You will receive a receipt at the time a withdrawal or transfer to or from your account is made using an ATM or POS terminal. All transactions with the Card will appear on your monthly Checking Account statement.

**9. ADDITIONAL CARDS.** You may request an additional card for yourself or your joint account holder by contacting us. You are responsible for the use of each Card according to the terms of this agreement.

**10. LIABILITY.** If we do not complete a transfer to or from your account on time or in the correct amount according to our agreement with you, we will be held liable for your losses or damages. However, there are some exceptions. We will not be liable if (a) through no fault of ours, you do not have enough funds in your account to make the transfer; (b) if the ATM machine where you are making a withdrawal does not have enough cash; (c) if the terminal or system was not working properly and you knew of the breakdown when you started your transaction; (d) if circumstances beyond our control (i.e. flood, fire) prevent the transfer, despite reasonable precautions we have taken. There may be other exceptions stated in our agreement with you.

**11. FEE SCHEDULE.** ATM charges for your Card when used at a machine that is not operated by Baptist Health South Florida F.C.U. are listed below:

~We will charge \$1.00 for each withdrawal

~We will charge \$ .50 for each transfer or inquiry

The following fees apply to any transaction:

~A \$5.50 fee will be charged for transfers to cover overdrafts from a share account.

~A \$30.00 service charge will be assessed for transactions not covered by sufficient funds

(Withdrawals, Transfers and Inquiries are **Free** at Presto Network ATMs)

**12. CREDIT INFORMATION.** You authorize the credit union to obtain such credit information relating to you as we deem necessary in order to carry out the terms of this Card service agreement.

**13. PURCHASES AND CASH ADVANCES IN FOREIGN CURRENCIES.** Purchases and cash advances made in currencies other than U.S. Dollars will be converted to U.S. dollars under regulations established by VISA International and may include a margin and/or fees charged directly by VISA International. Conversion to U.S. dollars may occur on a date other than the date of the transaction; therefore, the conversion rate may be different from the rate in effect at the time of the transaction. You agree to pay the converted amount.

**14. DEFAULT.** If you file for bankruptcy, use the card to exceed the balance on your Primary Account (if sufficient covering funds are not available in other accounts you have or are a joint member on), or default on this or any other agreement you have with us, we may terminate your privileges to use your Card, demand immediate payment of any overdrafts (including any charges and/or interest described in the agreements governing your Designated Account(s)) and demand immediate return of the Card.

**15. TERMINATING YOUR PRIVILEGES TO USE THE CARD.** You may terminate your Card privileges at any time by notifying us in writing. We may suspend or terminate your Card privileges at any time without prior notice. We may also reissue a different Card, and at this time you must return the existing Card to us upon request.

**16. AMENDMENT.** You acknowledge and agree that this Baptist Health South Florida F.C.U. Check Card Agreement is subject to change at any time by Baptist Health South Florida F.C.U. You will be notified by us, as required by law.

**17. DELAY IN ENFORCEMENT/WAIVERS.** We may delay or waive the enforcement of any of the provisions of this Agreement without losing our right to enforce the same terms at a later date. You understand that we will not be liable for a merchant's refusal to honor your Card whether the error was made by us, by the merchant, by an authorization agent, or by a third party.

**18. CHANGE OF NAME, ADDRESS, TELEPHONE NUMBER, OR EMPLOYMENT.** You will notify us immediately, in writing, if your name, home address, or employment changes.

**19. APPLICABLE LAW.** The laws of the State of Florida shall govern this agreement to the extent that those laws are not pre-empted by applicable federal law.

**20. JOINT LIABILITY.** If more than one person has agreed to this policy, "you" and "your" will apply to each of you. All Cards and monthly statements may be mailed or delivered to the address present on your Primary Checking Account Statement. This means that each of you will have the right to use the Card, and each of you will be liable for any overdrafts resulting from the use of the Card.

**21. ERROR RESOLUTION.** Contact the credit union at either (305) 662-8138 (South Miami Hospital branch) or (786)596-5918 (Baptist Hospital branch), or write to: 6200 SW 73 ST, Miami, FL 33143 (South Miami Hospital branch) if you believe there is an error in your statement or receipt, or if you need more information regarding a statement or receipt. You must notify us within 60 days from the time we sent you the first statement in which the problem or error appeared. When you call or write to us in regards to the discrepancy, you should tell us your name, account number, address, and telephone number. Describe the error or transfer you are unsure about and explain, as clearly as possible, why you believe it is an error or why you need more information. If you verbally, we may request that you send us your complaint in writing within 10 business days. We will tell you the results of our investigation within 10 business days after we hear from you. Then, we will correct any confirmed errors promptly. We may take up to 45 days to investigate a complaint. If it takes up to 45 days to investigate and fix the problem, we will re-credit your account within 10 business days for the amount that you think is an error. This is done to give you access to the funds in question while we complete our investigation. If we ask you to put your question in writing and we do not receive it within 10 business days, we may not re-credit your account. If we decide that there was no error, we will send you a written explanation within 3 business days after our investigation is completed. You may ask for copies of documents used in the investigation of your complaint.

**22. DISCLOSURE OF ACCOUNT INFORMATION TO THIRD PARTIES.** We will disclose information to third parties about your account or the transfers you make: (a) Where it is necessary in order to resolve the errors made to your account; (b) In order to verify the existence and condition of our account to a third party, such as a credit bureau or merchant; (c) In order to comply with laws and regulations and with subpoenas or orders of courts or government agencies; and/or (d) If you give us written permission.

**23. SECURITY INTEREST.** As a condition for approval for a Baptist Health South Florida F.C.U. VISA Check Card, you grant Baptist Health South Florida F.C.U. a security interest in the shares and deposits in all joint and individual accounts you have with the Credit Union now and in the future. Deposits in an Individual Retirement Account (IRA) and any other account that would lose special tax treatment under State and Federal law, if given as security, are not subject to the security interest you have given in your shares and deposits. You also understand that Baptist Health South Florida F.C.U. may enforce the agreed-upon security interest against funds you have deposited at the Credit Union to the extent of any direct or indirect indebtedness relating to the VISA Check Card regardless of whether you are a single or joint party on the account(s), and without prior notice to you. Evidence of your consent to the above conditions for obtaining this card is indicated by your signature(s) on the Check Card application and/or the use of the Card.

**24. ADDITIONAL TRANSACTION LIMITATIONS.** Transfers or withdrawals from Saving account(s), Money Market(s), and Checking account(s) are subject to the following limitations: Federal regulations limit the number of transfers or withdrawals that can be made electronically during any month. You may make no more than six (6) transfers and withdrawals, or a combination of such transfers and withdrawals, per calendar month, or to another account of yours to a third party by means of a pre-authorized or automatic transfer, a telephone response system, or a computer banking system. Overdraft protection transfers from your savings account are included in this limitation. In addition, no more than three of the six transfers may be made by check, draft, debit card, or similar order made by you and payable to a third party. Once you reach this limit, you will receive an error message stating that you have reached your monthly limit, and your account may be subject to closure.

**25. OTHER TERMS AND CONDITIONS.** Your accounts may also be governed by other terms and conditions previously set by us. If any of those terms or conditions conflict with the terms and conditions of this disclosure statement, this disclosure statement will prevail.



# VISA CHECK CARD APPLICATION

**SECTION 1** **APPLICANT**

NAME \_\_\_\_\_ HOME ADDRESS \_\_\_\_\_  
 SOCIAL SECURITY # \_\_\_\_\_ CITY / STATE / ZIP \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
 HOME TELEPHONE \_\_\_\_\_ EMPLOYER'S ADDRESS \_\_\_\_\_  
 WORK TELEPHONE \_\_\_\_\_ CITY / STATE / ZIP \_\_\_\_\_

**SECTION 2** **JOINT APPLICANT**

NAME \_\_\_\_\_ HOME ADDRESS \_\_\_\_\_  
 SOCIAL SECURITY # \_\_\_\_\_ CITY / STATE / ZIP \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
 HOME TELEPHONE \_\_\_\_\_ EMPLOYER'S ADDRESS \_\_\_\_\_  
 WORK TELEPHONE \_\_\_\_\_ CITY / STATE / ZIP \_\_\_\_\_

**SECTION 3** **SIGNATURE**

I / WE CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. I / WE AUTHORIZE THE CREDIT UNION TO VERIFY MY CREDIT INFORMATION. IF THIS APPLICATION IS APPROVED, THE UNDERSIGNED WILL BE BOUND BY THE TERMS AND CONDITIONS ACCOMPANYING THE VISA CHECKCARD.

X \_\_\_\_\_ DATE X \_\_\_\_\_ DATE  
 APPLICANT'S SIGNATURE JOINT APPLICANT'S SIGNATURE

**CREDIT UNION USE ONLY**

\_\_\_ APPROVED \_\_\_ REJECTED DATE \_\_\_\_\_  
 NO. OF CARDS \_\_\_\_\_ COMPLETED BY \_\_\_\_\_  
 MEMBER SELECT PIN: Yes: \_\_\_\_\_ No: \_\_\_\_\_