Holiday Club Account Agreement

Account #: _____ Date: _____

Member Name: _____

I hereby request the NIH Federal Credit Union to open a Holiday Club Account. I agree to be bound by the terms and conditions of this account as identified below. Account restrictions are subject to change. Funds from this account will be transferred to your primary share account on November 1st; or on the next closest business day following November 1st.

1. A minimum initial deposit of $5.00 is required to open the account.
2. This account will pay dividends at a rate set by the NIH Federal Credit Union, compounded and posted monthly. Dividends will be paid from day of deposit to day of withdrawal.
3. The account summary will appear on quarterly account statements.
4. There are no deposit restrictions on this account relating to the frequency of deposits or the manner in which they are to be made.
5. Funds from this account will be transferred to your primary share account on November 1st, or on the next closest business day following November 1st.
6. Should the member need to withdraw funds at a time other than the scheduled disbursement date, a check for the balance in the Holiday Club Account will be issued and the account will be closed to further activity. The member will not be eligible to reopen the Holiday Club Account until after the next renewal period (November 2nd).
7. All funds in this account will be released to the member upon termination of the account providing there are no fees, delinquent loans or other monies due the Credit Union.
8. All accounts will be automatically renewed each year. Any member wishing not to renew must notify the Member Services Department prior to a disbursement date.
9. All accounts are federally insured by the National Credit Union Administration, a United States Government Agency, to a maximum coverage to each member of $250,000.

Please transfer $ _____ from the below account to open my Holiday Account.

☐ Savings-Suffix: ____ ☐ Checking-Suffix: ____ ☐ Other-Suffix: ____

X _____ _____

Member Signature Date

ID Type: NIH ID

ID Number: _____

Expiration Date: _____

X _____ _____ _____

NIHFCU Associate Signature Date NIHFCU Associate Print Name

To submit, please fax or mail completed and signed form along with any requested support documentation to:

NIHFCU Attention: Operations Department

Fax: **301.770.5372**

Mail: **P.O. Box 6475 Rockville, MD 20849-6475**

Or, you may drop this form off at any NIHFCU branch location