Certificate Request Form

Account #: _____ Date: _____

Member Name: _____

Address: _____ _____ _____

Contact Phone #: _____

Deposit Amount: _____ Amount of check enclosed: _____ Transfer from: _____ - ____

Account Number Suffix

Dividends to be Paid: (please select one)

☐ Reinvest ☐ Transfer to: _____ - ____

Account Number Suffix

Type of Certificate:

Please Select One

Term of Certificate:

Please Select One

Maturity Options: (please select one)

☐ Reinvest ☐ Transfer to: _____ - ____

Account Number Suffix

_____ _____

Member Signature Date

ID Type: NIH ID

ID Number: _____

Expiration Date: _____

_____ _____ _____

NIHFCU Employee Signature Date NIHFCU Employee 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