



Credit Card Balance Transfer Request Form

Name of Creditor: _____
Payment Address: _____
Account Number: _____
Amount: _____

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Payment Address: _____
Account Number: _____
Amount: _____

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Payment Address: _____
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Name of Creditor: _____
Payment Address: _____
Account Number: _____
Amount: _____

Name of Creditor: _____
Payment Address: _____
Account Number: _____
Amount: _____

Member Signature: _____

Date: _____ Member Number: _____

PLEASE EMAIL THE COMPLETED FORM ALONG WITH A COPY OF YOUR DRIVER'S LICENSE TO GSAFCU@GSA.GOV