ACU OF TEXAS
ASSOCIATED CREDIT UNION

Member Refund Request Form

Date:_____ Account:_____

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Work/Mobile:_____

Date of Fee(s):_____ **Amount:**_____

Please provide a brief explanation regarding the reason for the requested fee refund. It will be reviewed and you will receive a response in writing within 7-10 business days. PLEASE DO NOT CALL FOR STATUS UPDATES DURING THE REVIEW PERIOD. We appreciate your patience.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Member Signature:_____

Please return your request to: Associated Credit Union of Texas, Attn: Refund Request P.O. Box 9004 League City, TX 77574 (or) fax the form to 409-942-1577.

Credit Union Use Only

_____Approved _____Denied

Decision by:_____

Amount of Refund (if applicable):_____