DOMESTIC WIRE TRANSFER REQUEST

Please complete and sign the form below then mail or fax to:
Mail: CommonWealth One Federal Credit Union
P.O. Box 9997
Alexandria, VA 22304-0797
Fax: (703) 650-4003

CommonWealth One Federal Credit Union
Your Lifetime Financial Partner

Domestic Wire Transfer Fee: $15

MEMBER INFORMATION

MEMBER NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

ACCOUNT #: _____

AMOUNT: _____ **TIME RECEIVED:** _____

RECEIVING BANK

ABA #: _____ **ABA Lookup**

BANK NAME: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

FURTHER CREDIT TO/FINAL RECEIVING BANK (IF NEEDED)

ABA #: _____

BANK NAME: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

ACCOUNT TO BE CREDITED

MEMBER NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

ACCOUNT #: _____

REASON FOR WIRE: _____

SPECIAL INSTRUCTIONS: _____

CommonWealth One Federal Credit Union shall mail a transaction receipt of each wire transfer and fees charged to the member no later than the next business day following the date of the transfer. Such receipt shall be sent to the member's address of record. CommonWealth One agrees that it will use its best effort to see that requests for transfers are handled promptly and consummated on the day of receipt but makes no representation of such handling and the Member agrees that CommonWealth One is not responsible for any loss resulting from delay in making a transfer.

MEMBER'S SIGNATURE: _____

PHONE: _____

DATE: _____

FOR OFFICE USE ONLY

WIRE AGREEMENT SIGNATURE VERIFICATION: _____ WIRE AGREEMENT PASSWORD VERIFICATION: _____

EMPLOYEE TAKING REQUEST: _____ BRANCH: _____

ACCOUNTING USE ONLY

OFAC CHECK BANK: _____ OFAC CHECK RECIPIENT: _____

EMPLOYEE COMPLETING WIRE SIGNATURE: _____ PRINT LAST NAME: _____