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## **Privilege Pay Program Opt-Out or Opt-In**

### ***Opt-Out***

I hereby request Arkansas Federal Credit Union to cancel Privilege Pay on my checking account. I understand if funds are not available in my account, all debits to my account may be returned and an overdraft fee of \$25 will be assessed for each item returned. *This form will not affect any overdraft lines of credit nor will it affect any transfers from other accounts that you may have selected.*

\_\_\_\_\_  
Name

\_\_\_\_\_  
Member Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### ***Opt-In***

I wish to enroll in the Credit Union's Privilege Pay Program. I agree to the terms as provided in the Credit Union's disclosure, policy, and fee schedule regarding the Privilege Pay Program. I understand that my account must be eligible as described in the disclosure or this Opt-In will not be valid.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Member Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **Parental Consent**

(for primary members age 16-17 years)

As the parent or legal guardian of a checking account holder-age 16 or 17 years-I authorize the enrollment of Privilege Pay on this checking account. I am also a joint owner on this checking account.

\_\_\_\_\_  
Parent Name

\_\_\_\_\_  
Member Number

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

*For Internal Use Only*  
*Enter name & teller number after updates made*

\_\_\_\_\_  
Employee Name and Teller Number