



Account Closure Request Form

Member Name: _____

Member Account Number: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Reasons for account closure, please describe:

I hereby that I am an authorized account holder of the account listed above. I authorize DC Credit Union to initiate the request of this form.

Primary Member Signature

Date

For Office Use Only:

Member Representative Initials: _____ Date: _____

PLEASE FAX TO 202-673-3508 OR EMAIL TO INFO@DCCREDITUNION.COOP