



Affidavit for Unauthorized use of a Visa Debit or ATM Card

Please complete this form if your Visa debit or ATM card has been used fraudulently. As part of this process, your card will be deactivated.

If you're disputing an *authorized* Visa debit transaction, please complete the Cardholder Dispute Form instead of this Affidavit.

If you're disputing charges made on a Visa *credit* card, please call Cardholder Services at 1-800-654-7728.

Member Information	
Member name (primary accountholder)	Member name (joint accountholder)
Residence address	City State ZIP
Account number	Phone ()
Card Information	
Card number _____ Expiration date _____ <input type="checkbox"/> Lost <input type="checkbox"/> Never received <input type="checkbox"/> Stolen <input type="checkbox"/> Other (Please explain circumstances.)	
I first learned of the loss on _____ at _____. Date Time	
I/we have reported the crime to the following law enforcement agency, _____, on _____ Date. The case number is _____.	
Circumstances	
(When and how was the card lost or stolen, where, by whom, etc.? Please explain all details.)	
I/We have reason to believe that _____ misused the referenced card. Said person obtained possession of the card under the following circumstances. (Please provide details.)	
I/We have reason to believe the referenced card is now in the possession of: Name _____ Address _____ Phone _____	

Unauthorized Charges/Withdrawal Information

The following ATM/Visa debit card purchases or withdrawals from my/our Checking/Savings account at School Employees Credit Union of Washington were not made, authorized, approved, or ratified by me/us or such signers. (Please attach a sheet listing additional transactions, if necessary.)

Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____
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Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____
Date ___/___/___	Merchant's name _____	Amount \$ _____

Signature(s)

I/We have not received any part of the proceeds and will not benefit in any way, directly or indirectly, from the fraudulent transactions made with my/our card.

I/We authorize School Employees Credit Union of Washington, or any other victim of the actions outlined above, to initiate criminal proceedings against the individual(s) that have defrauded my/our name.

If I/we at any time receive any restitution for this claim, I/we will promptly remit the funds to School Employees Credit Union of Washington.

I/We recognize that false statements made in this affidavit with the knowledge of their falsity may subject me/us to civil liability and criminal penalties.

Signature of primary accountholder

Date

Signature of joint accountholder

Date

Please fax the completed form to Credit Services: **(206) 676-3649**

Please mail the original signed document to Credit Services: **P.O. Box 576, Seattle, WA 98111-0576**

The original signed document is needed for our records. Provisional credit can be issued based on the faxed copy.

Questions? Please call **(206) 628-6055** or **1-888-628-4010, ext 6055**.