

Account Closure Authorization

Fill out this to authorize the closure of your account from a previous financial institution. Select how you would like to receive your remaining balance. Submit this form to the financial institution where you will be closing your account.

3 2 1 3 7 9 9 1 5

Notification of Account Closure Authorization

To Whom it May Concern,

Financial institution

Address

City, State, Zip

Please close my account

Account #

Primary Owner

Address

City, State, Zip

Please send the remaining balance to:

Please indicate if the remaining balance should be deposited electronically (if available) or have a check forwarded to your mailing address.

Please deposit my check to my account listed below.

Account #

ABA /
Routing #

Please deposit my check to my address listed below.

Signature _____ **Date** _____

Name

Address

City, State, Zip

Phone Number