Tsunami Enterprises

A Non-Profit Organization

P.O. Box 608
Ukiah, CA 95482
Phone: 707-463-2546
Fax: 707-462-6235
www.tsunami-enterprises.org
justin@tsunami-enterprises.org

P.O. Box 6189
Santa Rosa, CA 95406

Instructions for Completing the Client Intake Packet

1) If this is the first time the client is applying for a Representative Payee, please be sure to complete the SSA-795 Statement of Claimant, one for the beneficiary and one for a 3rd party who knows the beneficiary and the SSA-787 Physician's Statement form included in this packet. If SSA has already determined the client must have a Representative Payee, or if the client already has a Representative Payee other than Tsunami Enterprises, completing these forms is not necessary.

2) Complete all the included forms and get client signature where needed.

3) Submit copies of at least 1 photo ID.

4) In order to assist in developing an accurate budget, please provide copies of the following:

    a) Rental/Admission Agreement – Changes in living arrangement must include a copy of this document. Without an agreement to provide to SSA, there may be delays in receiving appropriate benefits.
    b) Utilities such as PG&E, or any other propane/gas/electric utility bill.
    c) City or County water, sewage and garbage bills.

5) Ensure client receives a copy of signed pages.

6) Intake packet can be mailed, faxed or emailed, using the above contact information.

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A Non-Profit Organization
Phone 707.463.2546 * Fax 707.462.6235

Date Recv'd	Recv'd By

Intake Form

Client Name: _____

Physical Address: _____

City, State, Zip: _____

Mailing Address: _____

City, State, Zip: _____

Phone #: _____ Message Phone #: _____

How long have you been at this address? _____

If less than 2 months at current address, provide the following:

Previous Address: _____

City, State, Zip: _____

Date of Birth: ___/___/___ Social Security #: _____

Place of Birth: _____ Drivers License #: _____

Current Marital Status:

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Annuled
- ☐ Widowed

Next of Kin Name: _____ Relationship: _____

Mailing Address: _____

City, State, Zip: _____

Phone #: _____ Message Phone #: _____

Former Payee Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone #: _____ Message Phone #: _____

☐ SSA ☐ SSI ☐ VA ☐ Other: _____

Referring Agency: _____

Contact Name & Number: _____

Is the Claimant Conserved? Yes / No County: _____

Conservator Name / Phone #: _____

I Live: ☐ Alone ☐ With Someone

Name: _____
Relationship: _____
Name: _____
Relationship: _____

Monthly Rent: _____

Landlord Name: _____ Ph# _____

Facility License#: _____ *(if applicable)*

Mailing Address: _____

City, State, Zip: _____

Phone #: _____ Message Phone #: _____

Do you have cooking facilities? Yes / No Do you have a refrigerator? Yes / No

Utilities & Bills to Be Paid: Please complete now or call in the amounts due when you receive your bills.

Name of Account	Account #	Address

Or you can have your bills sent directly to P.O. Box 608, Ukiah, CA 95482

After Rent, Utilities and Bills are paid, I would like my Food & Supply money to be:

☐ Divided into 2 checks and mailed to me on the **1st and 15th** of each month

or

☐ Divided into 4 checks and mailed to me on the **1st, 8th, 15th and 22nd** of each month

or

☐ Weekly - Circle Day - (Monday) (Wednesday) (Friday)

or

☐ Other _____

Do you have a checking account? Yes / No Bank name: _____
Acct #: _____

Do you have a savings account? Yes / No Bank name: _____
Acct #: _____

If you are interested in direct deposit please provide the routing number below.

Routing #: _____

Has Claimant had any marriages? Y / N Did it last longer than 10 years? Y / N

Name of Spouse: _____

City & State of Marriage: _____ Children? Y / N

From: ____/____ to ____/____ # of Children: _____

Did marriage end due to death of spouse? Y / N

Did Claimant become disabled before age 22? Y / N At what age? _____

Is Claimant currently working? Y / N Date of Hire: ____/____/____

Employer: _____

City & State: _____ Hours / Week: _____

Pay Frequency: Weekly / Semi-Weekly / Monthly Hourly Rate: $ _____

IF YOU ARE WORKING, ALL PAYSTUBS MUST BE PROVIDED TO TSUNAMI ENTERPRISES, COPIES ARE ACCEPTABLE.

Unearned Income? Yes / No

PLEASE CHECK ALL THAT APPLY

☐	Private Pension	$ _____
☐	Unemployment	$ _____
☐	Dividends	$ _____
☐	General Assistance	$ _____
☐	Alimony	$ _____
☐	Rental Income	$ _____
☐	Child Support	$ _____
☐	Trust Fund	$ _____

Additional Resources? Yes / No

PLEASE CHECK ALL THAT APPLY

☐	Stocks / Bonds	$ _____
☐	Trust	$ _____
☐	Real Estate	$ _____
☐	Burial Plot	$ _____
☐	Life Insurance	$ _____
☐	Car / Motorcycle / Trailer / Boat	

Year: _____

Make: _____

Model: _____

THE RESOURCE LIMIT IS $2000 FOR A SINGLE PERSON AND $3000 FOR AMARRIED COUPLE. THE LIMIT APPLIES TO SSI AND MEDI-CAL ONLY.

Do you have a valid current will? Yes / No Date signed: ____/____/____

Executor Name: _____

Executor Phone #: _____

Do you have an established pre-need burial plan? Yes / No

Mortuary Name: _____

Mortuary Phone #: _____

Identification Verification

Collect a copy of as many of the following as is available: (circle copied items)

Photo ID SSA Card MediCare Card MediCal Card Other: _____

Have you ever been convicted of a crime (other than a simple traffic offense)? Yes / No

If so, please provide the following:

Offense: _____

Date: _____ Misdemeanor / Felony

Which Court: _____

Disposition: _____

Did you serve any time in jail other than awaiting trial? Yes / No

Do you have any fines or restitution from this conviction? Yes / No

Are you paying monthly? Yes / No If so, how much? $ _____

Remarks / Requestes / Notes: _____

***** For Tsunami Enterprises use only ***** TRP Input: _____ Date: _____

Advance Notification of Representative Payment

Name of Wage Earner, Self-Employed Person or SSI Claimant	Social Security Number
Name of Beneficiary (if other than above)	Relationship to Wage Earner, Self-Employed Person or SSI Claimant

I understand and agree with the following:

Need for Representative Payee

The Social Security Administration (SSA) has decided that I need someone to manage my benefits. Because of this, SSA will send my benefits to a Representative Payee. It is the duty of the Representative Payee to use my benefits for my best interests.

Choice of Representative Payee

SSA has selected **TSUNAMI ENTERPRISES** to be my Representative Payee.

My Right to Appeal

I understand that I have the right to appeal SSA's decision. I can appeal the choice of who will be the Representative Payee. In most cases, I can also appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in file and submit new evidence. I understand that I can have a friend, lawyer or someone else help me.

I understand that I must file an appeal within 60 days. If I file after the 60 day period, I must have a good reason for not having filed this appeal on time. I have to ask for the appeal in writing. I will contact an SSA office if I wish to appeal.

Signature	Date

Witnesses are required **only** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and ZIP Code)	Address (Number and Street, City, State, and ZIP Code)

Form SSA-4164 (9-94)
Destroy prior editions
*U.S. Government Printing Office: 1994 - 300-946/00180

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Tsunami Enterprises

A Non-Profit Organization

PO Box 608 * Ukiah, CA 95482 * Phone 707.462.2546 or 707.462.6023 * Fax 707.462.6235

Authorization to Release Information

To: Tsunami Enterprise, Inc.

Name: _____

SSN: _____ Date of Birth: _____

I hereby give my consent to **Tsunami Enterprises, Inc.** to obtain and/or exchange information for the purpose of either panning for my well-being and/or assuring my continuing eligibility for Social Security benefits.

I also hereby give my consent to **Tsunami Enterprises, Inc.** to obtain and/or exchange information regarding the item(s) below for the pupose of planning for my well-being.

☐ Social Security Number	☐ Account Ledger/Statement	☐ Current Monthly SSA/SSI
☐ Bank Account	☐ Burial Trust	☐ MediCal/MediCare
☐ Wages/Employment	☐ Utility Bills	☐ Social History
☐ Address/Living Arrangement	☐ O.H.S. Plan/Appointments	☐ Other (explain below)

_____

_____

_____

I am the individual, to whon the requested information/records applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare that I have examined all of the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that Tsunami Enterprises, Inc. is not responsible if a person authorized to obtain information regarding my account does so with false pretenses and Tsunami Enterprises, Inc. is not responsible for any effect to my benefits caused by releasing the requested information.

_____ _____

Print Name Date

_____ _____

Signature of Beneficiary or Legal Guardian Relationship (if not beneficiary)

_____ _____

Tsunami Enterprises, Inc Staff Member Date

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Agreement For Services

I, _____, have discussed my needs with and agree to have Tsunami Enterprises serve as my representative payee for Social Security and/or SSI payments.

I will:

- Be clean and sober when conducting business with Tsunami Enterprises,
- Treat staff with courtesy and respect,
- Receive money for spending as agreed,
- Provide receipts when needed and/or requested.

I understand that if I fail to comply with these rules, Tsunami Enterprises may refuse to continue to serve as my representative payee. I also acknowledge that Tsunami Enterprises assumes no responsibility or liability to me or others in making disbursements based on information or instructions I have provided or within the Social Security Administration Guidelines and other legal/regulatory requirements.

Tsunami Enterprises will:

- Treat me with courtesy and respect,
- Use funds received on my behalf to meet my current and immediate needs,
- Report to SSA any events or changes that may affect my benefits
- Account to SSA on how my funds have been spent or saved,
- Save any unspent funds, if any,
- Return to SSA any funds that have been saved or to which I am not entitled.

_____

_____

Print Name _____ Date _____

Signature of Beneficiary or Legal Guardian _____ Relationship (if not beneficiary) _____

Tsunami Enterprises, Inc Staff Member _____ Date _____

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Budget Worksheet

Effective Date: _____

Client Name: _____

Client SSN: _____ Date of Birth: _____

I N C O M E

TYPE	AMOUNT	FREQUENCY	VENDOR NAME & ADDRESS
SSI Benefits			
SSA Benefits			
Other			

L e s s E X P E N S E S

Rent			
Electricity			
Gas			
P&I			
Other			
Other			
Other			
Payee Fee			

TOTAL: _____

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WHAT HAPPENS AFTER I SIGN UP FOR TSUNAMI ENTERPRISE SERVICES?

1) If the intake is completed before the SSA "cut-off" date for the month (normally the 2nd Friday of the month) then Tsunami Enterprises should start receiving your benefits the following month.
    a) Example: If the intake packet is completed on January 7th, then Tsunami Enterprises would start receiving your benefits in February.
    b) Example: If the intake packet is completed on January 20th, the Tsunami Enterprises would start receiving your benefits in March.
    - **DUE TO CHANGES WITHIN SOCIAL SECURITY'S PROCEDURES, A CHANGE IN REPRESENTATIVE CAN TAKE UP TO 3 MONTHS OR LONGER ON A CASE BY CASE BASIS.**

2) If your benefits are currently suspended, Tsunami Enterprises will work with SSA to get your benefits reinstated as quickly as possible. Please understand that Tsunami Enterprises is not SSA and does not have direct access to the information SSA has on file. We work with SSA by telephone, fax, in-person, etc.

3) When calling Tsunami Enterprises, if your worker is not available, **leave only ONE voicemail**. Please give your worker at least 1 business day to reply to your request.

4) After SSA processes the Representative Payee Application and notifies Tsunami Enterprises, you will be given the information on who will be working with you for your day to day budgeting needs and how to contact that person by telephone and email.

5) Personal and incidental funds are included as part of your monthly budget. If you have additional funds available after your budgeted expenses are set, you may request to have a portion of those funds issued to you.

6) Please provide receipt copies for extra expense requests.

7) Checks are mailed the day before the checks are due. If your check is scheduled for the 1st of the month, it will be mailed the day before the first (last day of the previous month).

8) If you are scheduled to receive a check on a holiday or a weekend, you should receive your check the day before the holiday or weekend.

9) Tsunami Enterprises observes all Federal holidays and as such will be closed on those days.

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Form Approved
OMB No. 0960-0045

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER - -
NAME OF PERSON MAKING STATEMENT *(If other than above wage earner, self-employed person, or SSI claimant)*	RELATIONSHIP TO WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that -

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
SIGN HERE ▶	Telephone Number *(Include Area Code)* ( ) -

Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*

City and State	ZIP Code -

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

1. Signture of Witness	2. Signture of Witness
Address *(Number and street, City, State, and ZIP Code)*	Address *(Number and street, City, State, and ZIP Code)*

Form Approved
OMB No. 0960-0045

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NAME OF WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT	SOCIAL SECURITY NUMBER - -
NAME OF PERSON MAKING STATEMENT *(If other than above wage earner, self-employed person, or SSI claimant)*	RELATIONSHIP TO WAGE EARNER, SELF-EMPLOYED PERSON, OR SSI CLAIMANT

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SIGNATURE OF PERSON MAKING STATEMENT

Signature *(First name, middle initial, last name) (Write in ink)*	Date *(Month, day, year)*
SIGN HERE ▶	Telephone Number *(Include Area Code)* ( ) -

Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*

City and State	ZIP Code -

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Address *(Number and street, City, State, and ZIP Code)*	Address *(Number and street, City, State, and ZIP Code)*

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

PAPERWORK REDUCTION ACT:

This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 10 minutes to read the instructions, gather the necessary facts, and answer the questions.

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Include Area Code)
( )

DATE

SSA CONTACT

Privacy Act: This report is authorized by sections 205(a) and 205(j) of the Social Security Act, as amended (42 U.S.C. 405(a) and 405(j). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
__ __ __ / __ __ / __ __ __ __

PATIENT'S NAME

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

PATIENT'S SOCIAL SECURITY NUMBER
__ __ __ / __ __ / __ __ __ __

PATIENT'S DATE OF BIRTH

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. **Please Note:** This determination affects how benefits are paid and has no bearing on disability determinations. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

1. Date you last examined the patient _____ .

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean that the patient:

- Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes — If "Yes", please omit question 3, but be sure to sign and date the form.

☐ No — If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

☐ Unsure — If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER *(Please print.)*	TITLE
ADDRESS *(Number and street, City, State, and ZIP Code)*	TELEPHONE NUMBER *(Include Area Code)* ( )

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/MEDICAL OFFICER	DATE

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A Non-Profit Organization

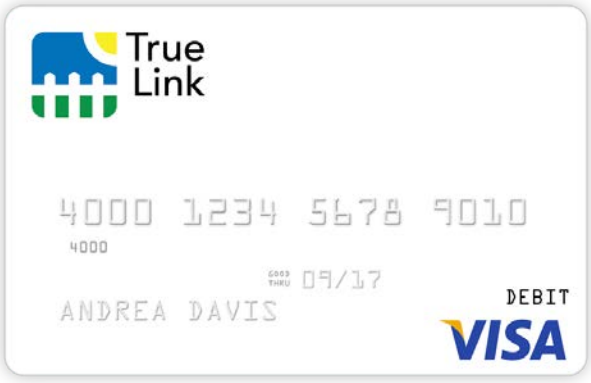
P.O. Box 608
Ukiah, CA 95482
Phone: 707-463-2546
Or 707-462-6023
Fax: 707-462-6235

Tired of your check arriving late due to Post Office changes, holidays, etc. Tsunami Enterprises is now able to provide direct deposit or recommend a debit card program.

For those with an already existing personal checking account, we can now offer **D**irect **D**eposit. If you do not already have a checking account, West America Bank offers a free checking account for all Tsunami clients.

DIRECT DEPOSIT
Simple. Safe. Secure.

For those that do not have or are unable to open a traditional personal checking account, the ***True Link Card*** offers the convenience of direct deposit for the cardholder.



True Link Prepaid Visa® Debit Card

For more information please visit *https://www.truelinkfinancial.com/schedule-of-fees-and-charges*.

*Tsunami pays the monthly maintenance fee for the prepaid debit card.

IF YOU ARE INTERESTED IN EITHER OF THESE OPTIONS, PLEASE CALL THE OFFICE AND WE WILL MAIL OUT THE APPROPRIATE FORMS TO YOU.

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Tsunami Enterprises, Inc.

P.O. Box 608, Ukiah, CA 95482
Ph.(707)463-2546 Fax(707)462-6235

Direct Deposit Agreement Form

Authorization Agreement

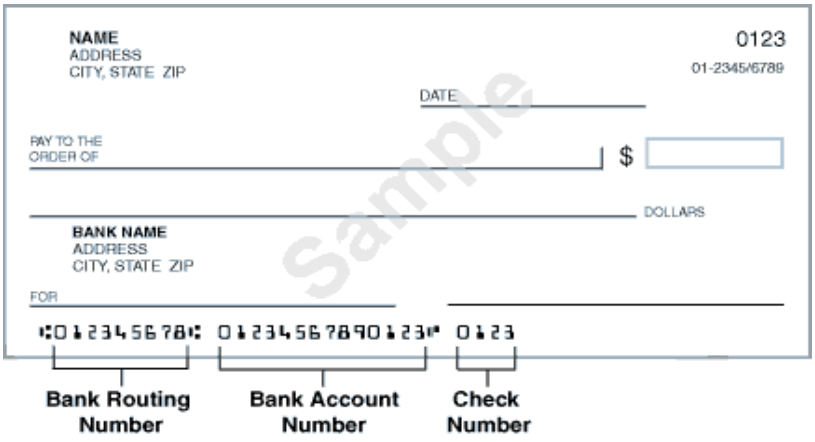
I hereby authorize Tsunami Enterprises, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Tsunami Enterprises, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Tsunami Enterprises, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Tsunami Enterprises, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Representative Payee Program.

Account Information

Name of Financial Institution: _____



Routing Number: _____

Checking
Account Number: _____

Signature

Print Full Name (Primary): _____

Authorized Signature (Primary): _____ **Date:** _____

Print Full Name (Joint): _____

Authorized Signature (Joint): _____ **Date:** _____

Please attach a voided check or deposit slip and return this form to Tsunami Enterprise, Inc.

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Beneficiary True Link Card Agreement

The True Link Card is a reloadable Visa card, which enables __**TSUNAMI ENTERPRISES**__ to make disbursements safely, quickly, and reliably. The card also allows beneficiaries and their representatives the freedom to purchase things that enhance their quality of life. Please read the rules below used to govern the card.

We require you to sign this Beneficiary True Link Agreement in order to use the card.

Terms of card use

- The card is not transferable, and cannot be resold or transferred for cash
- Lost/stolen cards will be replaced without charge one time per quarter (3 months), and a $5 replacement fee for additional cards charged by TrueLink against your card balance.
- For inquiries about card balance and transactions contact True Link at 1-800-299-7646.
- Cards will be shipped to you directly by TrueLink. As such you will need a physical address they can ship to, not a PO Box. If the card is returned due to incorrect mailing address, your funds will be frozen until Tsunami gets a good shipping address. Be sure Tsunami always has updated address information for you. SSA also relies on a good address and anything returned to SSA for a bad address will cause benefits to be suspended.

Funding schedule

- The card will be loaded with funds after rent and utilities are paid (CIRCLE ONE):
  (1ST) (1ST & 15TH) (1ST, 8TH, 15TH & 22ND) (MONDAYS) (WEDNESDAYS) (FRIDAYS)
- If you receive SSA (also known as SSDI) benefits then replace the 1ST with the 3RD.
- If the funding day(s) falls on a weekend or holiday, it is possible to receive funds on the first business day before the weekend or holiday. Please contact us for more information.

The undersigned agree to the rules set out in this Beneficiary True Link Agreement. If these rules are not followed or if the True Link Card is misused in any way, card privileges will be revoked.

_____
Printed Name

_____ _____
Signature Date

Please return this signed Beneficiary True Link Agreement to:

TSUNAMI ENTERPRISES
PO BOX 608
UKIAH, CA 95482
Fax (707) 462-6235

True Link Card Schedule of Fees and Charges

Fees for Set-Up and Maintenance		
Fee Type	**Fee Amount**	**How to Avoid or Reduce This Fee**
Monthly Fee	$10.00	***PAID BY TSUNAMI***

Fees for Adding Money (per transaction)		
Fee Type	**Fee Amount**	**How to Avoid or Reduce This Fee**
Direct Deposit	No Fee	
Funding from a Bank Account	No Fee	

Fees for Spending/Transferring Money (per transaction)		
Fee Type	**Fee Amount**	**How to Avoid or Reduce This Fee**
Signature and PIN Purchases – Domestic	No Fee	
International Signature Purchase	$1.00	
International PIN Purchase	$2.00	Use a signature instead of PIN to pay

Fees for Getting Cash (per transaction)		
Fee Type	**Fee Amount**	**How to Avoid or Reduce This Fee**
ATM Cash Withdrawal**	No Fee	
Cash Back at Point-of-Sale (select “Debit” and enter your PIN to get cash back when making purchase at a retailer)	No Fee	
Bank Teller Withdrawal (Over-the-Counter Cash Withdrawal using signature)	$4.00	Use an ATM or get cash at a point-of-sale terminal
Quasi-Cash Withdrawals (e.g., money orders, traveler’s checks, foreign currency, lottery tickets, casino chips, vouchers redeemable for cash)	$4.00	Use an ATM or get cash at a point-of-sale terminal
ATM Insufficient Funds**	No Fee	

Fees for Customer Service, Getting Information and Card Maintenance (per request)		
Fee Type	**Fee Amount**	**How to Avoid or Reduce This Fee**
Automated and Live Agent Phone Calls	No Fee	
Email and Text Message Alerts. Standard text messaging rates apply.	No Fee	
ATM Balance Inquiry**	$0.50	Check your balance online or by phone for no fee
Mailed Paper Statement	$1.50	View your statement online for no fee
Expedited Card Delivery (2 Day Delivery)	$30.00	Choose regular delivery speed for no fee

Fees for Transferring Money Out When Closing Your Account		
Fee Type	**Fee Amount**	**How to Avoid or Reduce This Fee**
Account Closure With Card-to-Bank Transfer*	No fee	
Replacement Card	No fee	
Account Closure With Check Refund	No fee	

* Bank where you maintain your bank account may impose a transfer fee.

** You may be charged a fee by the ATM operator or other networks used to complete the transaction (and you may be charged a fee for a balance inquiry at an ATM even if you do not complete a fund transfer). Such other fees and charges may be deducted from your Card Account.