ATM Fee Refund Request

(for *Extreme checking* accountholders only)

Name _____ Date _____

Card No. _____ Ph. No. _____

Account No. _____ Reimbursement Month _____

Customers participating in the Extreme Checking program will be reimbursed ATM fees charged by other vendors within the guidelines as established:

a) Print, complete, return or fax the form to any of our banking offices by the 10th of the month. If mailed, it needs to be postmarked by the 10th of the month.
b) Sending an e-mail request to customerservice@denalistatebank.com .

Reimbursement will be posted within 5 business days, unless otherwise notified. Reimbursed fee will be deposited to the account in which the fees occurred.

Bank use only - Processed by_____ Date _____ Total Refunded_____
Verified by_____ Date _____