



Cashier's Check Request Form

Date: _____

Account Holder's Name: _____

TAB Account Number: _____

Amount Requested: \$ _____

Check Payable to: _____

Address on Account: _____

City: _____ State: _____ Zip: _____

Address to Mail Check to: _____

(If different from the Account Holder's address)

City: _____ State: _____ Zip: _____

Signature of Account Holder: _____

Joint Account Holder's Signature: _____

(If required)

Please Select Appropriate Box and Initial:

- Cashier's Check Fee** – I authorized TAB to charge my account \$5.00 for issuing a cashier's check. Initial _____
- Cashier's Check Fee + Overnight Fee** – I authorize TAB to charge my account \$25.00 to overnight the cashier's check to the mailing address above. Initial _____

Fax Request to: (801) 624-5304

(For Office Use Only)

Request Processed by: _____ Date Processed: _____