16 Digit Card Number: _____ Name _____

	Date	Transaction Amount	Merchant Name Location/Phone #
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Please provide a detailed description of why you are disputing the above transaction(s).

Please remember to include the dates that you spoke with the merchant, who you spoke with, what the merchant stated, and any other information that will be helpful to continue our investigation.

_____

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To the Customer: The above information is true and to the best of your knowledge. Please sign below and return this form to us within 5 business days for Visa withdrawals and 10 business days for ATM withdrawals of the date you first reported the error. Return to the nearest office of Capitol Federal, or mail to: 700 Kansas Avenue, Topeka, KS 66603 or by fax to 785-231-6361.

I understand that Capitol Federal Savings will investigate the alleged error and notify me of the appropriate disposition of this matter.

Customer Signature: _____Date:_____