

Not in possession of Chelsea card lost/stolen/retained/not received



Please complete this form in **block capitals** and return to:

Chelsea Building Society, Thirlestaine Road, Cheltenham, Gloucestershire GL53 7AL

Name of card holder:

Account number:

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Daytime telephone number

I declare that my Chelsea card has been: (Please tick box A, B, C, D or E). A new card and PIN will be ordered upon receipt of this complete form

A Lost (complete section 2) **B** Stolen (complete sections 1 and 2) **C** Retained in a cash machine (complete section 2)

D Not received in the post (complete section 2) **E** Other reason (please specify):

Section 1

Details of loss/theft (please complete as fully as possible):

Date and time (approx.):

Address/location:

Circumstances:

Date informed police:

D	D	M	M	Y	Y	Y	Y
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Police station:

Crime ref. no:

Important additional information:

Was your Chelsea card stolen with your Chelsea chequebook: (Please tick box A or B)

A Yes (please complete details below) **B** No

Details of last cheque drawn on this account before the loss/theft are as follows

Payee:

Amount:

Cheque no:

Date of cheque:

Section 2

Declaration: In the event of the Chelsea card being found I undertake to return it immediately to Chelsea.

Signature:

Date

Web version

For office use only

ACC05 hot card (H)	Initials	Branch	Date									
Processed by:	<input type="text"/>	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	
D	D	M	M	Y	Y	Y	Y					
Important	Initials	Time	Advised to	Date								
ATM Section advised by phone:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y					
ACC05 new card and PIN (N)	Initials	Branch	Date									
Signature checked by:	<input type="text"/>	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	
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D	D	M	M	Y	Y	Y	Y					

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Referral made: (Tick as appropriate)	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
Processed by:	Initials <input type="text"/>	Date <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
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