|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | **Student’s Information** | | | |
| Parent’s Name |  | | Student’s Name | | |  |
| Address |  | | School of Higher Education | | |  |
| Phone |  | | Enrollment Date | | |  |
| **Withdrawal Request**  I wish to make the following request to my student’s Inversant account and understand the terms of such actions as I agreed to in the *Family Agreement*. I also understand that this payment must be requested at least **THREE** **weeks** prior to the deadline of the bill for processing purposes. | | | | | | |
| Type of Request | | Successfully Graduate  *\*****Please attach*** *with this form*  *1. Proof of enrollment of higher education*  *2. Proof of payment: tuition bill, invoice, receipt* | | Early Withdrawal | | |
| Total Saved | | $ | | $ | | |
| Total Matched | | $ | | There is no match if the parent withdraws early | | |
| Match Withdrawal Amount | | $ | | $ | | |
| Match Balance Remained | | $ | | This action will close this account | | |
| Reason/ Purpose of Payment | | Tuition Bill—payment will be made   directly to school  Books and supplies at campus   bookstore— payment will be made   directly to vendor  Parent—reimbursement of college expenses  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | The participant cannot meet attendance requirement  The participant cannot meet savings requirement  The participant is no longer involved with CHV  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Payment Due Date** | |  | |
| **Parent’s Signature** | |  | | **Date** |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| To: | Camp Harbor View Foundation Corporate Office | | | |
| From (Circle one): | Parent/CHV Staff/Inversant Staff | | | Date: |
|  | | | | |
| **Please make the following withdrawal** | | | | |
| Student Name: | |  | | |
| Total Check Amount: | | $ | | |
| Memo Line Comment: (*could insert student name and ID number if paying for college bill*) | |  | | |
| |  |  | | --- | --- | |  Mail Check to: | Name: | | School/Organization: (*optional to specify school’s billing department*) | |  | Street: | | City, State & Zip: | |  This transaction will close this account | | | | | | |
| Authorized CHV Staff Name (Printed): | | |  | |
| Authorized CHV Staff Name (Signature): | | |  | |
| CHV Finance Office Representative Name (Printed): | | |  | |
| CHV Finance Office Representative Name (Signature): | | |  | |
| Please deliver or email request to: | | | Camp Harbor View Foundation Corporate Office | |