Stop Payment Request Confirmation

Member Name: _____ Account Number:_____ Date:_____

Beginning Check Number: _____ Ending Check Number:_____ Check Amount: $_____

Notified the Credit Union by: ☐ In Person ☐ Mail ☐ Telephone ☐ Email

Reason: _____

_____

Please stop payment on the check(s) described above. I understand the oral stop payment will lapse within fourteen (14) calendar days if form is not signed and returned. Once received, the stop payment order will be effective for six (6) months from the date above. The undersigned agrees to hold the Credit Union harmless for said amount and for all expenses and costs incurred by it on account of refusing payment of said check, and further agrees not to hold the Credit Union liable on account of payment contrary to this request, if same occur through inadvertence or accident, or if by reason of such payment other items drawn by the undersigned are returned insufficient. Further, the undersigned reaffirms the terms and conditions set forth in the Membership Account Agreement, which is incorporated herein by reference.

NOTE: This Stop Payment Order applies to any actions to submit the item specifically described in the paper form which you tender to the party listed as "Payable To" above. The Credit Union is not able to control the actions of third persons; and therefore is not responsible or liable for any actions undertaken by any person that results in an alteration of the Check described herein, or any action to convert the item to an ACH or other electronic item that is then submitted for payment.

Member Signature: _____ **Date:** _____

Credit Union Use Only:

Oral Request taken by: _____

Employee Signature **Date** **Time request was taken.**

Mail/In-person
Request processed by: _____

Employee Signature **Date**