



**STOP PAYMENT REQUEST
CHECK/DEBIT AUTHORIZATION**

Account Number: _____

Member: _____

CHECK ACH Debit

Amount of Check/Debit Authorization: _____

First Check Number: _____

Ending Check Number: _____

Date of Check/Debit Authorization: _____

Payee: _____

Stop Reason: _____

Intent: _____

Daytime Phone: _____

I request that the Credit Union stop payment on the check described on this Stop Payment Request and on any debit from my account described in this Stop Payment Request initiated by or from that check.

I understand and agree that this Stop Payment Request is effective only for a period of 180 days. I may renew this Stop Payment Request for another 180 day period prior to the expiration of the initial 180 day period.

By directing the Credit Union to stop payment on the above transaction(s), I agree to hold the Credit Union harmless against any and all loss, claims, damages, and costs, including court costs and attorney's fees, that the Credit Union may suffer or incur by reason of non-payment of the above transaction if presented prior to withdrawal of these instructions or expiration thereof.

I also understand that it is necessary to provide the correct information related to the transaction(s) and that failure to do so may result in the payment of the above item(s). I agree to hold harmless and indemnify the Credit Union for all expenses, costs, and damages incurred by payment of the above item(s) if such payment is the result of my failure to provide this Stop Payment Request in time to allow the Credit Union reasonable opportunity to act upon it, or if such payment is the result of my failure to furnish any item of information requested above completely, accurately, and correctly.

Verbal Request

Member Signature _____

Date _____