

The Friendly place to bank.

STOP PAYMENT FORM

Stop payments are not guaranteed for the first 24 hours

Date: _____

Employee Initials: _____

Name: _____

Member Number: _____

REASON FOR STOP:

- PAYEE NEVER RECEIVED:
- UNAUTHORIZED:
- LOST/STOLEN:
- DUPLICATE PAYMENT:
- FRAUDULENT TRANSACTION:
- OTHER: _____

\$25.00 FEE FROM: Checking Savings

CHECK STOP

Check Amount: \$ _____ Payable to: _____

Check #: _____ or Range of Checks From: _____ To: _____

ACH STOP

Savings Debit Checking Debit

Amount of authorized debit: \$ _____

Company Name: _____

One-Time ACH Stop Payment: 6 month Expiration Date

Recurring ACH Stop Payment: Zero Expiration Date

Member Signature

Date: _____

Office Use Only		
Draft Stop	ACH Stop	Fee Charged
Date Processed: _____		Processors Initials: _____
Date Sent to Member: _____		Date Received Back: _____
Expiration Date Updated: _____		Date Processed: _____

