Stop Payment Request

Member Name: ______________________________________

Account Number: ______________________________________

Date Of Check: ______________________________________

Check Number: ______________________________________

Check Amount: ______________________________________

Payable To: ______________________________________

Reason: ❒ Dispute w/Company ❒ Lost (i.e. in mail or stolen)

Please stop payment on the check described above, unless you have already paid, certified or accepted it. I understand that this request will cease to be effective six months from the date shown below, unless it is previously canceled or renewed in writing by me. Unless my signature appears below, the request was verbal and shall not be binding on USAgencies Credit Union beyond 10 days from the date of request unless confirmed by me in writing within the 10-day period. The Credit Union will not be liable for payment of the draft contrary to this request unless payment is caused by the Credit Union's negligence and causes actual loss to me. The Credit Union's liability shall not, in any event, exceed the amount of the check. I agree to reimburse the Credit Union for any loss it sustains in honoring this request. I certify by signing below, that I did not present a USAgencies Credit Union Check Guarantee card to the Payee herein named, nor does the Visa CheckCard number appear on the check(s) numbered above.

X______________________________________
Member Signature

X______________________________________
Date

______________________________**For Credit Union Use Only**______________________________

❒ Verbal Request

Fee Charged by:______________________Date: ______________Confirmed by: ______________________

Who phoned in:

❒ Member
❒ Joint

Phone#____Timed phoned in:______________……AM / PM