

Community Focus Federal Credit Union

18925 Telegraph Rd.
Brownstown, MI 48174
734-281-3900

STOP PAYMENT REQUEST: ACH and CHECKS

Date of Request _____ Account Number _____

Accountholder Name _____

Payee/Originator _____

Check/ACH Debit Date _____ Check Number (if applicable) _____

Amount \$ _____ Stop Payment Fee \$ _____

Reason for Stop Payment _____ (If required by FI)

Type of Transaction: ACH/Electronic Check Check

For check or ACH debit: I would like the above payment stopped one time.

The signed stop payment order will remain in effect for **six months on a check**, or **until the ACH debit entry is returned**, or until the stop payment order is withdrawn.

Stop Payment Terms and Conditions

I/we, the owner(s) of the account number listed above, instruct [the Financial Institution] to stop payment on the above transaction(s). I/we understand that if the stop payment is on a check, this stop payment order will expire in six months. If I/we wish to extend the stop payment, I/we understand I/we must renew it in writing. I/we understand that placing a stop payment on an ACH debit does not cancel my authorization with the Originator.

I/we understand that, by placing this stop payment request on the transaction(s) listed above that I agree to hold [the Financial Institution] harmless against any and all loss, claims, damages and costs, including court costs and attorney's fees that [the Financial Institution] may suffer or incur by reason of non-payment of the above transaction(s) if presented prior to withdrawal of these instructions, or the expiration thereof.

Timing of Stop Payment Order

I/we understand a stop payment order must be received by [the Financial Institution] in time to allow [the Financial Institution] a reasonable opportunity to act on it prior to acting on the debit entry; for pre-authorized ACH debit transactions, [the Financial Institution] may require a minimum of three banking days notice prior to the scheduled date of the transfer. To be effective, the stop payment order must sufficiently identify the payment. If this stop payment order is accepted orally and I am given notice that a signed confirmation is required, the signed confirmation must be received within fourteen (14) days of the initial oral order. Properly signed stop payment orders are effective for the period described above for the check or ACH debit(s) described above. By signing below I/we agree to all terms and conditions, of this Stop Payment Order.

I am an authorized signer or otherwise have authority to act on the account identified in this statement.

Authorized Signature _____ Date _____

Cancellation of Stop Payment Order

Date _____ Time _____ Authorized Signature _____

For [Financial Institution] use only

Verbal Request received Date _____ Time _____ By _____

Written Request received Date _____ Time _____ By _____

Company ID # _____ Fee _____ Date Stopped _____