1600 MEDICAL DRIVE ◆ POTTSTOWN ◆ PA ◆ 19464
(610) 326-5490 ◆ (800) 593-1000 ◆ FAX (484) 949-2577

Stop Payment Request Form

The following fee will be charged to your draft account for this request: **$24.00 fee for stop payment.**

Name: Account #: MICR #:

Date of Draft: Draft #: Amount of Draft:

Payable to:

Reason for Stop Pmt: ☐Lost ☐Stolen ☐Dispute w/ Payee ☐Other

I understand that if this request was made orally to the credit union, the stop payment request will be void unless I, the member, sign this form within 14 days of the initial oral request. I also 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. I understand it is not the credit union's responsibility to notify me when the time period lapses and if I choose to renew the stop payment request, I may be subject to pay another service fee. 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 draft. I agree to reimburse the credit union for any loss it sustains in honoring this request.

☐Telephone request

_____
Date Time

_____
Signature of Member Date

_____
Signature of Employee Date