Fitzsimons
A PARTNERING CREDIT UNION

Stop Payment Request

Request Received: ☐ In Person ☐ By Phone ☐_____

Date Accepted _____ 20_____ Time_____ A / P M

Draft Number_____ Draft Dated_____

Draft Payable to _____ Draft Amount_____

Reason for Stop Payment_____ Account Number_____

Fee_____

Account Name_____

This Credit Union and the undersigned hereby agree to abide by the rules and regulations (as outlined in Uniform Commercial Code) governing Stop Payment Orders. Oral Stop Payment Orders (including by phone) are binding for 14 DAYS ONLY, unless the Account Owner confirms the order with his signature (on the proper form) within the 14-day period. Properly signed Stop Payment Orders are effective for 6 months after the date accepted and will automatically expire after that period unless renewed in writing.

All stop payment orders are conditional upon our receiving the stop payment order in sufficient time for us to prevent the item from being processed and paid. We will advise you if we are not able to stop the item from being paid. Any provisional credit you receive upon the placement of a stop payment order will be reversed if we are not able to stop the item from being paid. If you have any additional questions regarding your rights or responsibilities with respect to a stop payment order, please refer to paragraph 16 of your Membership and Account Services Agreement.

Signature of Account Owner Date

RELEASE OF STOP PAYMENT ORDER

NOTICE: If you wish to release the Stop Payment Order described above, of if you have recovered the draft described above, please sign below the return this form to the Credit Union so we may remove the Stop Payment Order from our records.

The Stop Payment Order above is released as of the date shown below.

Signature of Account Owner Date