

HEALTH ONE CREDIT UNION

ACH STOP PAYMENT ORDER

REQUEST MUST BE COMPLETED IN FULL.

\$_____ Service Fee Will Be Charged to Draft Account

Date of Payment	Company ID	Amount of Payment	Payment Payable To:
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Routing Number: 272077984

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(Please Print)

Member's Name _____

Address _____

City/State/Zip _____

Home Telephone Number _____

Work Telephone Number _____

Please indicate Stop Payment Code

Unauthorized Drawer's Signature
 NSF (Not Sufficient Funds)
 Member Stop pay
 Closed Account

No Account
 Forged Endorsement
 Raised Item
 Restraining Order

Please stop payment on the ACH 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. I also understand that this stop payment could take up to **48 hours** to confirm. It is the member's responsibility to check their account for the next 48 hours to see if the payment has cleared their account. The Credit Union will not be liable for payment of the ACH item contrary to this request unless payment is caused by the Credit Union's negligence and causes actual loss to me. If the Company ID number is not available, I know that I am also responsible for any fees that may be charged because the stop payment is based only on the amount. 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. I also acknowledge receipt of this stop payment authorization.

Date of Request

Time of Request

Member's Signature

NOTIFICATION TO CHECK ALERT: (For lost or stolen checks) 1.800.926.5678

Date: _____ Driver's License #: _____ Placed by: _____

Police Report # _____

Copy Received by Member via Hand _____ Mail _____ Fax _____

CU Representative _____