

HEALTH ONE CREDIT UNION

STOP PAYMENT ORDER

REQUEST MUST BE COMPLETED IN FULL.

\$ _____ Service Fee Will Be Charged to Draft Account

Date of Draft	Draft Number	Amount of Draft	Draft 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 draft 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 check has cleared their account. 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. 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 _____