

Member Information

First Name Last Name
 E-mail Address Daytime Telephone

Today's Date
 Member Number

Please stop all future payments from the Originator

Originator Dollar Amount
 Reason for Stop Payment

Date scheduled

Please stop the next payment only from the Originator

Originator Dollar Amount:
 Reason for the Stop Payment

Date Scheduled

I hereby authorize the credit union to stop payment on the ACH items. For pre-authorized entries, three business day advance notice prior to the expected transfer date of the debit entry is required to implement the stop payment request. If the stop payment order is received within three business days of the expected transfer date, we will attempt to satisfy the request of the account holder, but will not be held liable if sufficient time was not provided for a pre-authorized transfer that occurs within the three business day period. I understand that the correct information on this request is necessary for the credit union to properly identify the ACH item.. I agree to hold the credit union harmless from liability, costs and expenses (including attorney fees) or other claims related to the credit unions action in 1) refusing payment of the item(s) or 2) in failing to stop payment of the item(s), including claims of any joint owner, payee or endorsee.

I authorize my account to be charged for this service in accordance with the "Schedule of Fees and Charges" in effect on the date shown above. A stop payment order will remain in effect until the earlier of 1) the withdrawal of the stop payment order by the Receiver, or 2) the return of the debit entry, or where a stop payment order is applied to more than one debit entry under a specific authorization involving a specific originator, the return of all such debit entries.

This form acknowledges the account holder's request to stop payment on pre-authorized electronic funds transfer as indicated above. The account holder further represents that the debit transaction(s) described above was not originated with fraudulent intent by me or any person acting in concert with me, and that the signature below is my own proper signature.

Member Signature

Please sign and return this form in person or submit through one of the following methods:

By Mail: 1069 Graves Ave, Suite 100 El Cajon, CA 92021
 By Fax: 619-588-2197

Date & Time Rcvd: _____ FM Completed by: _____ Fee Charged _____
 Stop Payment Expiration: _____ Comments: _____