

Stop Payment Order

****Checking Account

Today's Date

Member Information

First Name

Last Name

Member Number

E-mail Address

Daytime Telephone

Single Share Draft

Date of Draft

Draft Number

Payable to

Dollar Amount

Reason for Stop Payment

Range of Share Drafts

Beginning Draft

Ending Draft

Reason for Stop Payment:

I hereby authorize the credit union to stop payment on the above check(s). I understand that the correct information on this request is necessary for the credit union to properly identify the check(s). I understand that this stop payment request is conditional and subject to the credit unions verification that the item has not already paid, and I agree the credit union will have reasonable time in order to process my request. I understand that my stop payment order will automatically be cancelled after 12 months from the date shown above, unless it is previously cancelled or renewed in writing by me. 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. If my checks have been lost or stolen I also agree to immediately contact by telephone at 619-588-1515.

Member Signature _____ Date _____

Please sign and submit this form through one of the following methods:

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

Credit Union Use Only:

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