



Catholic United Financial CREDIT UNION

3499 Lexington Ave N
Saint Paul, MN 55126

Phone: 651-765-4132
Toll-free: 877-871-8313

www.catholicunitedCU.org

STOP PAYMENT REQUEST

Stop payment of checks or ACH payments.

EFFECTIVE DATE: _____ MEMBER NAME: _____ ACCT#: _____

Please indicate the below the item(s) that you are requesting a stop payment. There is a \$20.00 fee per order.

Stop Payment of Check

Check Number: _____ Payable To: _____ Amount: _____

On the terms below, I hereby instruct CUFCU to stop payment on the above transaction(s). It shall remain in effect for 6-months.

Stop Payment on One Consumer ACH Payment (SINGLE ENTRY, WEB or TELEPHONE)

Company & Description: _____ Amount: _____

On the terms below, I hereby instruct CUFCU to stop payment on the above transaction. It shall remain in effect until I revoke the stop payment request or until the payment of the entry has stopped, whichever occurs first.

Stop Payment on Recurring Consumer ACH Payment (PPD, IAT, WEB or TELEPHONE)

Company & Description: _____ Amount: _____

On the terms below, I hereby instruct CUFCU to stop all subsequent payments on the above transaction. I authorized the above Company to originate one or more ACH payments to debit funds from my account, but on Date: _____, I revoked that authorization by notifying the Company listed above in the manner specified in the authorization. I agree to provide CUFCU with written confirmation of revocation within 14 calendar days from today's date. If CUFCU does not received the required written communication, then it will honor subsequent debits to my account.

AGREEMENT: I understand a fee will be assessed to my account as payment for implementing this request. By directing CUFCU to stop payment on the above transaction(s), I agree to hold CUFCU harmless against any and all loss, claims, damage and costs, including court costs and attorney's fees, that CUFCU may suffer or incur by reason of non-payment of the above transaction(s) if presented prior to withdrawal of these instructions or expiration thereof. I understand that the stop payment request must be received at least three business days before a scheduled debit or in time to give CUFCU reasonable time to act upon it. I understand that it is necessary to provide accurate information related to the transactions(s) and that failure to do so may result in the payment of the above item(s). I agree to hold harmless and indemnify CUFCU for all expenses, costs, and damages incurred by payment of the above item(s) if such payment is the result of my failure to meet the time requirements noted above, or if such payment is the result of my failure to furnish any item of information requested above completely and accurately. I further state that the debit transaction(s) 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. I certify under penalty of perjury that the foregoing is true and correct.

MEMBER SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY:

VERBAL STOP PAYMENT REQUEST ACCEPTED BY EMPLOYEE: _____ DATE: _____

SIGNED STOP PAYMENT REQUEST ACCEPTED BY EMPLOYEE: _____ DATE: _____