United Catholics Federal Credit Union

Stop Payment Request - ACH

MEMBER NAME _____ ACCOUNT NO. _____

Home Telephone # _____ Cell # _____

PAYABLE TO/ORIGINATING COMPANY NAME _____

Transaction Amount $ _____ OR ☐ Any Amount

Check Serial Number _____ *(only for check-related debit entries)*

For all non-recurring, single transaction ACH payments, the stop payment request must be provided in a timeframe that allows reasonable opportunity for us to honor the request prior to finalizing the ACH entry.

Please indicate your specific choice for stopping payment from the Originating Company named above by checking the appropriate box:

- ☐ I wish to stop all future payment from this Originator indefinitely
- ☐ I wish to stop the next payment only

  (Future entries from the Originator are to be paid, unless I provide you with an additional stop payment order.)
- ☐ I wish to stop a series of payments

  Identify the payment dates, or months, of the specific payments from the Originator you wished stopped:

_____

A fee will be assessed to the account holder as payment for implementing this order:

Fee Assessed: $15.00

For pre-authorized entries, three (3) business days 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 (3) 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 (3) business day period. The account holder also understands that it is necessary to provide the correct information related to the transaction(s) sufficient to enable the identificiation of the account and transaction(s) in question.

This form acknowledges the account holder's request to stop payment on pre-authorized electronic funds transfers 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. I agree to indemnify and hold United Catholics FCU harmelss from any cost, claim liability, or damages, including reasonable attorney's fees that result from carrying out this "Stop Payment Authorization."

Members' Signature _____ Date _____

Please return this form to: UCFCU P.O. Box 4946 Covina, CA 91723 Fax: (626) 974-4473

For Financial Institution Use Only

Instructions Received By: _____ Date: _____ Time: _____

Request Received: ☐ FAX ☐ PHONE ☐ IN PERSON

Mailed to Member: _____ Date Received from Member: _____ Date