STOP PAYMENT REQUEST

☐ **CHECK** ☐ **ACH**

MEMBER NUMBER ____________

Primary Name		Joint Name	
Phone		Phone	
Email		Email	

CHECK STOP PAYMENT	ACH STOP PAYMENT
☐ 73 ☐ 75 ☐ 76 ☐ 77 ☐ 74	☐ 01 ☐ 73 ☐ 75 ☐ 76 ☐ 77 ☐ 74

Payable to:	Payable to:
Date of Draft:	Expected Date of ACH:
Amount:	Amount:
Check Number(s):	One time Stop(s) Six month Stop (m)
Notes:	Notes:

A Service Fee of has been charged to your account.

AUTHORIZATION

Please stop payment of the item described above unless you have already paid, certified or accepted it. Oral stop payments are effective for fourteen days only, unless written confirmation is received by Abbott Laboratories Employees Credit Union (ALEC) within 14 days. ACH requires a 3 business day notification before putting a stop payment. I understand that this request will cease to be effective six months from the date shown below unless it is previously cancelled or renewed in writing by me. The credit union will not be liable for payment for the item contrary to the 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 item. I agree to reimburse the Credit Union for any loss it sustains in honoring this request.

SIGNATURE X_________________________ DATE ________________

PLEASE SIGN AND RETURN WITHIN 14 DAYS

Fax: 847-786-8322 **Email:** Operations@alecu.org

CREDIT UNION USE ONLY

VERBAL

ID______ Date_________ Can_________

SIGNED

ID_______ Date_________ Can_________