Check Stop Payment Order

Member Information:

Name	Account Number & Suffix	Date of Request
Address	City	State Zip
Home Phone	Work Phone	

Stop Payment On The Following Check Number(s)

☐ **Single Check:** Check Number _____ ☐ **Range of Checks:** Beginning Number _____ Ending Number _____

Date of Check	Payable To	$ Amount

Reason (Optional)

I request SkyOne Federal Credit Union to Stop Payment on the check(s) described above unless it has already paid, certified or accepted. I understand this form is used to place a stop payment on a checking, money market, line of credit or visa account. This form is not used to place a stop payment on a Corporate Check.

I warrant that the check(s) description, including the exact check number(s), amount, and payee are correct. I understand that the EXACT check number(s) is necessary for SkyOne Federal Credit Union's computer to identify the check(s). If I give SkyOne Federal Credit Union the incorrect check number(s), or any other incorrect information, SkyOne Federal Credit Union will not be responsible for failing to Stop Payment on the check(s).

Unless cancelled or renewed by me in writing, I understand that this Stop Payment Order expires in six months. I agree that SkyOne Federal Credit Union will not be responsible for stopping payment unless my Stop Payment Order is received by SkyOne Federal Credit Union within a reasonable time for SkyOne Federal Credit Union to act on my order. I understand that my Stop Payment request is conditional and subject to SkyOne Federal Credit Union's verification that the check(s) has not already been paid or that some other action to pay the check(s) has not been taken. In any event, SkyOne Federal Credit Union's liability will not exceed the amount of the check.

I agree to indemnify and hold SkyOne Federal Credit Union harmless from all costs, including attorney's fees, (to the extent permitted by law) damage or claims related to SkyOne Federal Credit Union's action in refusing payment of the check(s), including claims of a Joint Owner, Payee, or Endorsee, or in failing to Stop Payment as a result of incorrect information provided by me.

Unless cancelled or renewed by me in writing, I understand that this Stop Payment Order expires and is no longer in effect six (6) months from the original Date of Request. I understand that I may make an oral Stop Payment Order which will lapse within fourteen (14) calendar days unless confirmed in writing within that time.

Verbal Request must be followed up by a signed confirmation copy within fourteen (14) days of original request or this Stop Payment Order will be cancelled

I agree to its terms and conditions. I understand that I must pay a Stop Payment fee of $20.00, which will be deducted from my checking account.

Member Signature **Date**

Cancellation (The above Stop Payment is hereby cancelled)

Member Signature **Date**