PALMETTO HEALTH Credit Union
Where it all adds up for you.

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STOP PAYMENTREQUEST

Stop Payment Order

Account Number:	Check Number:	Check Amount:
Date of Check:	Replacement Check Issed: ☐Yes ☐No	Replacement Check Number:
Date of Stop Payment Request:	Time of Request: ☐AM ☐PM	Method of Request ☐In Person ☐By Mail ☐Phone

MEMBER AUTHORIZATION

Please stop payment on the check listed above. This stop payment order will be effective for six (6) months from the "Date of Stop Payment Request" above. The undersigned agrees to hold the Credit Union harmless for said amount and for all expenses and costs incurred by it on account of refusing payment of said check, and further agrees not to hold the Credit Union liable on account of payment contrary to this request, if same occur through inadvertence or accident, or if by reason of such payment other items drawn by the undersigned are returned insufficient. Further, the undersigned reaffirms the terms and conditions set forth in the Membership Account Agreement, which is incorporated herein by reference. NOTE: This Stop Payment Order applies to any actions to submit the item specifically described in the paper form. The Credit Union is not able to control the actions of third persons; and therefore is not responsible or liable for any actions undertaken by any person that results in an alteration of the Check described herein, or any action to convert the item to an ACH or other electonic item that is then submitted for payment.

Signature _____ Date _____ Signature _____ Date _____

STOP PAYMENT REQUEST CANCELLATION/RENEWAL

The Stop Payment is hereby: (choose one as applicable) Canceled/Renewed for an additional 6 months from this date

Member Signature _____ Date _____ Member Signature _____ Date _____

FOR CREDIT UNION USE ONLY

Employee Name:	Request Type: ☐ Written ☐ Oral
Comments:	

Revised: 2014 04