FAX TO: 847-670-0401
ATTENTION: STOP PAYMENT DEPARTMENT

STOP PAYMENT FORM

(PLEASE PRINT)

Date of Initial Request: _____

Member Name_____

Address:_____

City State Zip:_____

Home phone number: (_____) _____-_____ Work phone number: (_____) _____-_____

Stop Payment Fee
$15.00

For a range of
Checks $30.00

STOP PAYMENT (CHECK)

.....Routing & Transit #..... ……..Account #……..…….. ..Check#...

Please copy the information exactly from the MICR Line, Example: :271975401:00000123456789 0456

Account# 00000☐☐☐☐☐☐☐☐ From Check# _____To Check#_____

Payable to: _____ Check Amount $_____

STOP ELECTRONIC PAYMENT (EFT/ACH)

METRO Account# ☐☐☐☐☐☐☐ [ ] Savings Suffix 00 [ ] Withdrawal [ ] Amount_____

Expected [ ] Checking Suffix 80 [ ] Deposit

Transaction Date ____/____/____ [ ] Checking Suffix 81

Company ID: _____Company Name:_____Description:_____

1. **Item Description.** I request METRO Federal Credit Union to stop payment on the share draft/check, preauthorized electronic funds transfer ("EFT"), or ACH draft ("item") described above. I warrant that the item description, including the date or expected transfer date, its exact amount, the check number and payee are correct. I understand that the EXACT information on the item is necessary for METRO Federal Credit Union's computer to identify the item. If I give METRO Federal Credit Union the incorrect amount or any other incorrect information, the Credit Union will not be responsible for failing to stop payment on the item.
2. **Stop Payment Order.** I agree METRO Federal Credit Union will not be responsible for stopping payment unless my Stop Payment Order is received by the Credit Union: (1) within a reasonable time for the Credit Union to act on my order prior to a final payment or similar action; or (2) at least three (3) business days before the scheduled date of the preauthorized EFT or ACH draft. I understand that my stop payment request is conditional and subject to METRO Federal Credit Union's verification that the Item has not already been paid or that some other action to pay the Item has not been taken. I understand that my Stop Payment Order will be effective as follows: A written Stop Payment Order will be effective for 12 months. A written Stop Payment Order may be renewed in writing from time to time. I also agree to notify METRO Federal Credit Union promptly upon the issuance of any duplicate Item which replaces the Item subject to this order or upon return of the original Item. I agree to pay METRO Federal Credit Union a stop payment fee for each request as set forth above.
3. **Indemnification.** I agree to indemnify and hold harmless from all costs, including attorney's fees, (to the extent permitted by law) damage or claims related to the Credit Union's action in refusing payment of the Item, including claims of any joint owner, payee, or endorsee, or in failing to stop payment of an Item as a result of incorrect information provided by me. *NOTE: Stop Payment Requests are processed only during business hours.*

Member Signature: X_____ **Date:** _____

Stop Payment Fee of

$_____
was deducted from your account.

FOR CREDIT UNION USE ONLY: **DATE AND TIME REQUEST RECEIVED**

_____

Attach a copy of the computer screen and have supervisor initial stop payment form.

REVIEWED BY: **DATE:**

METRO FEDERAL CREDIT UNION
2440 E. Rand Road
Arlington Heights IL 60004
Main (847) 670-0456
Fax (847) 670-0401