None Suffer Lack

Federal Credit Union

You must complete, print and sign this form. You may mail or bring this form to the None Suffer Lack FCU at 4929 Allentown Road, Suitland MD 20746 or fax this form to 301.899.0305.
Your signature is required to complete this process.

STOP PAYMENT REQUEST ORDER

Date: _________ **Member Name:** ____ **Cell #:** ____________

Account Number: ______________ **Expected Clear Date for ACH:** ___________

Payable to: ____

Transaction Amount: $ ______________ **Check No(s):** ________________ **Date Check(s) Written:** ______________

Reason for Stop Payment: ____

For pre-authorized entries, three business days advanced 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 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 three 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 identification of the account and transaction(s) in question. ________ (**Member Initial Here**)

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 payments from the Originator indefinitely
- ☐ I wish to stop the next payment only *(Future entries from this 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 $25.00 fee will be assessed to the member's account as payment for implementing this stop payment request.
___________ (Member Initial Here)

This form acknowledges the account holder's request to stop payment on pre-authorized electronic funds transfers as indicated above. The member 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.

____ __________________________________

Member Signature **Date**

Credit Union Use Only:

Instruction Received by: ______________________ **Date:** _______________ **Time:** ____________