PARKWAY FEDERAL CREDIT UNION

Stop Payment Form

(MEMBER MUST COMPLETE THE TOP PORTION OF THIS FORM)
(I must provide the exact amount, check number, company name in order for the stop to be processed)

Today's Date: _____ Time:_____ Branch_____

Account Number: _____ Members Name:_____

☐ Written Authorization Sharedraft ☐ ACH ☐

Sharedraft

Reason for the Stop Payment: (check one) **(Stop payments can only be placed for the following reasons)**
Lost_____ Stolen _____ Account is being Closed _____

Routing & Transit Number from draft _____ Draft Numbers _____

Amounts:_____ Payable To:_____

Please stop payment on the draft described above, unless you have already paid or accepted it. I understand that this written request will cease to be effective six months from the date shown below and an oral request will cease to be effective fourteen days from the date shown below unless it is previously canceled or renewed in writing by me. The credit union will not be liable for payment of the checks contrary to this request unless payment is caused by the credit union's negligence. I agree to reimburse the credit union for any loss it sustains in honoring this request.
Once a stop payment is placed on a check or a series of checks, the stop payment cannot be removed. All checks that are submitted as a stop payment are no longer valid checks and should be destroyed.

ACH Written Authorization

I wish to stop the deduction from my Parkway Federal Credit Union account.
Company Name or Description_____
Company ID# (if available)_____ Amount of Deduction $_____
The deduction will be debited from my account on _____
Reason for the Stop Payment _____

(In order for a stop Payment to be placed, all information must be provided exactly as it will appear when submitted for payment)

I understand that this stop payment of the above mentioned item is either a permanent stop or a stop for one payment or deduction.
I will not hold Parkway Federal Credit Union liable for non-payment as a result of this stop payment. I understand that I must contact the company to inform them of the stop payment and it is not the responsibility of the credit union. I also understand that if the deduction is for an insurance company, that it is my responsibility to contact them to make other arrangements for payment and that they may cancel my policy or coverage at any time.

I understand that there is a $30.00 stop payment fee for the above mentioned item. I also understand that I will be liable for any items presented within 72 hours from the date and time this request is signed. Any item that clears prior to the 72 hr. period is the responsibility of the member.

The stop payment for the above mentioned item is: ☐ **A one time stop payment** ☐ **A permanent stop payment**

Did I contact the Company in which I am placing the stop payment ☐ **Yes** ☐ **No**

I understand and I was advised that the only way to guarantee that the deduction will be stopped would be to close the account. The credit union is not responsible for future deductions from your account

_____ _____
Members Signature Date

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Employee That Accepted form Must Complete This Section

Member Account Number Cencorp_____

USTP Was Placed on Acct. _____ (initial) Employee Signature _____

This Area is to be Completed by the Accounting Clerk

Date Stop Was Placed _____ Time _____ Conformation # _____

Acct. Clerk Signature _____

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