STOP PAYMENT REQUEST
CHECK/DEBIT AUTHORIZATION

Lisbon Community Federal Credit Union
Building Futures. Preserving Dreams.

DATE: _____ EXPIRATION DATE (6 MO.): _____

CREDIT UNION: _____ ACCOUNT NUMBER: _____

MEMBER NAME: _____

ADDRESS: _____

_____

DATE CHECK WAS WRITTEN: _____ CHECK NUMBER:_____

AMOUNT OF CHECK/DEBIT AUTHORIZATION: _____

PAYEE: _____

CHECK WRITTEN FOR: ☐ BUSINESS ☐ INDIVIDUAL

I request that the Credit Union stop payment on the check described in this Stop Payment Request and on any debit from my account described in this Stop Payment Request initiated by or from that check. I understand there is a $20 charge for this request.

I understand and agree that this Stop Payment Request is effective only for a period of six (6) months. I may renew this Stop Payment Request for another six (6) month period prior to the expiration of the initial six (6) month period.

I also understand that the Credit Union has no liability or responsibility to me or anyone else for any reason if I do not provide this Stop Payment Request to the Credit Union in time to allow the Credit Union a reasonable opportunity to act on the Stop Payment Request before it acts on the check and/or debit authorization.

MEMBER SIGNATURE: _____

PLEASE MAIL THIS FORM TO: PO BOX 878, LISBON, ME, 04250
OR FAX THIS FORM TO: 207-353-7615

Credit Union Use Only

INITIALS OF MSR: _____ **VERIFIED BY:** _____

Give a photocopy to the ACH person. If check is for an Individual, enter both check number and amount in menu 421 (Stop Menu).

Revised 10/10