Finger Lakes Health Care
Federal Credit Union

Notice of Stop Payment Request:
CHECK

Member Name: _____ Account #: _____

Check #:_____ Amount: _____

Payee: _____

Reason: _____

Stop Payment Request Date: _____

Stop Payment Expiration Date: _____

I understand that this request for stop payment is valid only for the item(s) listed above. I further understand that the item(s) mentioned above will only be stopped if it is presented to the credit union as a paper check. Any items presented electronically (by ACH) will not be stopped.
I understand that the fee for the stop payment request will be deducted from my account.

The fee will be: **$20.00 for Member Share Draft**
(circle appropriate fee) **OR**
$20.00 for Bank Cashier Check

_____ _____
Signature **Date**

For Credit Union Use Only:

Accepted by: _____

Date: _____

Verified by: _____